

NATHAN  
BERGER  
Afghanistan  
Studies  
Project

**Final Report**

# **Survey on Afghan Drug Use, Attitudes, and Media Accessibility**

**Submitted to the  
Office of the A.I.D. Representative  
for Afghanistan Affairs**

**Under  
Contract No. 306-0205-C-00-9385-00  
Delivery Order No. 24**

**November 1992**

**Submitted by  
Nathan Associates Inc. and  
Louis Berger International, Inc.  
A Joint Venture**

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# Preface

This report was prepared in response to Delivery Order 24 of A.I.D. Contract No. 306-0205-C-00-9385-00, the Afghanistan Studies Project. The work was carried out by the joint venture of Nathan Associates Inc. and Louis Berger International, Inc.

The field work took place during June–September 1992. The field work was performed and the report was prepared by a team consisting of Dr. Thomas Timberg (team leader), Dr. Elham-Eid Alldredge, Mr. Jeffrey Miller, and Dr. Hans Spielmann. In addition, survey work inside Afghanistan was carried out by Isatullah (chief investigator), Abdul Aziz, Abdul Wakeel, and Abdul Waris.



# 1. Introduction

This report contains the results of one of a series of three narcotics studies conducted by the Nathan-Berger joint venture under the Afghanistan Studies Project. The first study focused on the production of opium and heroin, and the second study addressed strategy options that the U.S. government could choose to control opium and heroin production and use in Afghanistan. This study focuses on the demand for narcotics in Afghanistan. Specifically, this study examines attitudes of Afghans toward drugs, the extent of drug addiction among Afghans, and Afghans' accessibility to media that might be used to influence their attitudes toward drugs.

Heroin use is believed to be spreading in Afghanistan. Ten years ago, heroin use in neighboring Pakistan was negligible, but now Pakistan is estimated to have 1 million or more heroin addicts. Just as opium and heroin production in Pakistan and Afghanistan are closely connected, the problem of addiction will not stop at the Pakistan-Afghanistan border. Approximately 3 million Afghan refugees have lived in Pakistan since 1979. Contact between Afghans and Pakistanis, as well as the hardships of life in the refugee camps, is likely to have resulted in the spread of Pakistani addiction to Afghanistan.

In the *Opium Subsector Survey*, the first report of this series, the Nathan-Berger team reported that Afghanistan's production of raw opium has reached substantial levels since the Russian invasion of 1979. In addition, the laboratories that refine opium into heroin appear to be moving from the tribal territories of Pakistan's Northwest Frontier Province (NWFP) into Afghanistan. Based on the experience of other countries, the expected pattern would be for addiction to follow the path of production into Afghanistan.

One of the objectives of this study is to provide an accurate picture of Afghans' current attitudes toward and practices in opium and heroin use, as well as their access to communications media, that could be used to influence their attitudes.

Other objectives of this study include the establishment of a baseline data set on drug attitudes and practices to permit assessment of the effects of future antidrug projects, and a report on attitudes toward the use of drugs—focusing on heroin—which can help A.I.D. create a drug strategy for Afghanistan.

## ORGANIZATION OF THE REPORT

This report has seven chapters. After the introduction, Chapter 2 briefly summarizes the history of opium cultivation in Afghanistan and how it was transformed into a major cash crop. To determine the extent of opium cultivation, two individual surveys examining the attitudes of Afghan refugees were conducted, the design of which is presented in Chapter 3. In Chapter 4 the results of the two surveys are presented and analyzed. Chapter 5 gives estimates of narcotics use from different perspectives: health workers, treatment population, and the surveys. The types of media that might affect users' attitudes are discussed in Chapter 6. Finally, Chapter 7 details the options, based on the survey findings, that policy makers might consider in determining a drug policy for Afghanistan. The appendix is a list of persons interviewed for this report.

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## 2. History of Opium in Afghanistan

Opium has a long history in Afghanistan; it has been cultivated in various provinces for centuries and has been used primarily for medicinal purposes. The transformation of opium poppy into a major cash crop is a phenomenon of the last few decades. Poppy cultivation has increased dramatically since the Russian invasion of 1979, primarily because of (1) a general absence of government or central authority in rural areas, (2) disruption of traditional transport and market systems, and (3) the effect on farmers of war-induced deprivation and poverty.

In their 1972 study *Poppies in Afghanistan*, Owens and Clifton found poppy cultivated in four provinces: Nangarhar, Qandahar, Balkh, and Badakhshan. Today most poppy production occurs in southwestern Afghanistan, particularly in northern Helmand, and the eastern provinces, especially Nangarhar. Poppy cultivation is reported to be considerable but decreasing in Badakhshan. Some poppy growing takes place in the central provinces Unuzgan and Bamyān; the northern provinces Balkh, Faryab, and Jawzjan; and in the far western province Herat. These areas appear to be small centers of production, but information is limited.

The most salient reason for the provincial pattern of cultivation seems to be the attitudes of local authorities. Those in some former opium growing provinces, such as Konar, have shut down the trade, just as others such as Akhunzada in Helmand actively promote poppy cultivation.

Except for Badakhshan, poppy in most areas of Afghanistan is irrigated—planted in the fall and harvested in the spring. Poppy cultivation has two labor intensive phases: hoeing and harvesting. An adequate supply of skilled labor is crucial for a successful harvest because the poppy pods must be incised and the raw opium collected several times during a period of approximately 2 weeks.

All sizes of farmers cultivate opium poppy under various tenurial arrangements. The most common estimates for yields are 30 to 40 kg per hectare. Nathan-Berger's *Opium Subsector Survey* estimated net returns of approximately \$2,500/ha. This figure is several times higher than the returns for wheat, the most common alternative to poppy.

In southwestern Afghanistan, most farmers sell their opium gum produce immediately after harvest to traders or agents of processors. Some poorer farmers short-sell their standing crops for 60 to 70 percent of their postharvest value. Many farmers take their produce directly to opium markets; others have their own processing arrangements or sell their opium directly to processors. Processing of opium into heroin was formerly done in tribal areas in Pakistan; however, to an uncertain extent, it is now moving into Afghanistan itself.

Almost all the opium-producing farmers, except those in Badakhshan, are Afghan Pashtuns, as is the general population in the opium-growing areas. Among the opium traders, processors' agents, and collectors and transporters to the Pakistan-Afghanistan border in the southwest are many Afghan Baloch. The traders in eastern Afghanistan and Badakhshan are also Pashtuns—either Afghans, or natives of Pakistan's tribal areas (Pashtun tribes such as Shinwari, Mohmands, and Afridi). The processors in the southwest are both Pashtun and Baloch. Most of the processors in Khyber are tribal area Pashtuns.



### 3. Database

Our basis for determining the current state of knowledge of, attitudes toward, and use of heroin and other illicit substances in Afghanistan includes the results of two surveys: one conducted in the refugee camps in Afghanistan by the Narcotics Awareness and Control Project (NACP) in 1991 and the other conducted in the summer of 1992 in several sections of Afghanistan for the purposes of this report (hereinafter the Nathan-Berger attitudes survey, or NBAS).

#### DESCRIPTION OF SURVEYS

##### **Narcotics Awareness and Control Project Camp Survey**

In the summer of 1991, the NACP conducted an awareness survey among Afghan refugees. The survey was originally intended to be conducted in 15 provinces inside Afghanistan. Because of a deterioration in the Afghan situation, field work had to be shifted to Afghan refugee camps in Northwest Frontier Province (NWFP) and Balochistan. More than 2,500 respondents were interviewed.

The original sample consisted of respondents from 15 provinces subdivided into districts and randomly chosen with probability of selection proportional to province and district size. Forty-eight districts were chosen and about 80 interviews in each district (3,900 in total) were to be conducted in four segments. The interviewees were to be selected randomly. A selection plan for interviewees was devised to select sample households within a chosen community. The intra-district sample frames had been drawn when the entire survey was canceled.

The interviewers were highly qualified because they had been recently dismissed by the Afghan interim government and were seeking employment. Twenty-four candidates were trained in a 3-day course and during a 4-day stay at a refugee camp. Of these candidates, 16 were selected and sent for a 5-day stay inside Afghanistan, where pretest interviews were conducted.

A few days after field work inside Afghanistan started, the survey had to be shifted to the camps, and the field procedures had to be modified. The camps in the NWFP and in Balochistan were chosen randomly, according to their reported population size. To take advantage of the situation the number of provinces was enlarged. An advance team (consisting of a Pakistani to contact the Pakistan authorities and an Afghan to contact the camp elders) was sent out to lay the foundation for the fieldwork, which lasted from early August to mid-September 1991.

When the NACP was terminated at the end of 1991, the data had been entered in the computer. However, not all the data were recovered nor was a report made. Some files seem to have been lost.

##### **Nathan-Berger Attitudes Survey**

The NBAS is part of the second of three narcotics studies conducted for the Afghanistan Studies Project. Because of changing priorities within A.I.D., this study was completed last.

The first study, *Opium Subsector Survey*, covered the cultivation of opium inside Afghanistan (the world's second largest producer of opium after Burma), the processing of opium into heroin on both sides of the Pakistan-Afghanistan border, and options for curtailing opium production.

The third study, *A.I.D. Mission Options for a Drug Control Strategy*, drew on conclusions reached in the *Opium Subsector Survey* and preliminary conclusions from this use and attitudes study.

The objectives, described in the introduction, were designed to be met through the administration of the NBAS (a modified version of the NACP survey) in Afghanistan and a comparison of its data with those from the NACP survey. In addition, medical personnel were to be surveyed to determine the extent to which heroin addicts appear among their patients. Also, the report was to include more general information gathered from interviews and secondary literature.

The NBAS consisted of four parts: (1) a questionnaire on attitudes, (2) a questionnaire for heroin addicts, (3) a questionnaire for medical personnel, and (4) a community profile. The questionnaires were translated into Dari (Persian). Four Afghan surveyors—all Pashtuns—administered the questionnaires.

The original plan targeted communities in six provinces: Nangarhar, Kabul, Helmand, Herat, Balkh, and Badakhshan. From each survey area 50 (100 from Kabul) respondents were to be interviewed. Moreover, health workers within these communities and drug users were to be interviewed with separate pro formas. In addition, community narcotics profiles were to be made for each area.

## LIMITATIONS

Neither survey was conducted as planned. The NACP survey had to be shifted from Afghanistan to the refugee camps, and the NBAS survey "lost" its northern and western sample areas (Herat, Balkh, and Badakhshan) as a result of fighting in Kabul and on the roads. In Kabul, the downtown areas could not be surveyed because of fighting. However, fieldwork was conducted in Ghazni as an alternative.

Because the NBAS team could not move as quickly as expected within a survey area, the data collection from health workers and drug users did not proceed according to plan. For example, The psychiatric hospital in Kabul, which might have been a good source, had been closed down. The team managed to interview only 14 health workers and 12 drug users. Three hundred fifty-eight attitude pro formas and 14 community narcotics profiles were completed.

Given the circumstances under which the teams had to operate, their achievement is not a minor one. The major aims were fulfilled.

Compared with the NACP teams, the NBAS team had received less training, and, in view of the time constraints, pretesting for the four pro formas was held to a minimum. Because the members of the team had previously been involved in the NACP survey, they were familiar with the subject, as well as the approach to and application of the attitude proforma.

## DEMOGRAPHIC BRIEFS

### NACP Respondents

The 2,551 NACP respondents were exclusively males. Their average age was 35.5 years (with a range from 16 to 76), and 44 percent were illiterate (22 percent had received primary, 26 percent secondary, and 7 percent higher education). Most were married (80 percent), and 60 percent were head of their household. Ethnically, they were composed of Pashtuns (67 percent), Tajiks (10 percent), and Hazara (18 percent), and their mother tongues were Pashto (73 percent) and Dari (19 percent). Twenty-one provinces were represented. Not represented were the western provinces of Herat, Badghis, Farah, and Nimroz—refugees from these provinces had fled to Iran—and the central provinces of Bamyan, Baghlan, Ghor, and Uruzgan. Twenty-three percent had returned to their home village during the last

year for a period of up to 1 month and 13 percent for a period between 1 and 6 months. Thirty-two percent worked their fields there.

Respondents reported that members of their family back in the home village (83 percent) grew wheat on 14.9 jeribs of their lands, 15 percent cannabis on 1.8 jeribs, and 31 percent poppies on 1.9 jeribs. The family head decided which crops were to be grown (56 percent). Sixty percent reported self-sufficiency in wheat; 7 percent had surplus wheat to sell.

The majority of the refugees had been farmers (53 percent), with an average land-holding of 20.4 jeribs for those owning land; 10 percent owned no land. Other professions previously pursued by the respondents inside Afghanistan were businessmen (12 percent) and laborers (34 percent). Their current occupations were farmers (30 percent), students (17 percent), and unemployed (9 percent).

The position of respondents within their community were elders (9 percent), mullahs (5 percent), commanders (6 percent), and *shura* members (2 percent). The majority (62 percent) had been active in the resistance, on average, for 2.5 to 3 years.

### NBAS Respondents

The 358 respondents of the NBAS were also exclusively males; their average age was 39 years (with a range from 16 to 78); and 25 percent were illiterate (26 percent had received primary, 28 percent secondary, and 21 percent higher education). Most were married (82 percent), and 51 percent were head of their household. Twenty-nine percent were the head of household's son and 20 percent his brother. Ethnically, the respondents were Pashtuns (69 percent) and Tajiks (31 percent), and their mother tongues were Pashto (67 percent) and Dari (33 percent). They came from six provinces (Kabul, Ghazni, Wardak, and the poppy-producing provinces of Nangarhar, Helmand, and Qandahar).

Sixty-four percent had lived since birth in the community where the interview took place. Another 30 percent had lived there for more than 20 years, and 3 percent between 10 and 20 years. The ravages of war had destroyed their houses: only 30 percent reported no damage; 23 percent had repaired the damage; 19 percent had not yet made repairs; and 27 percent had their homes totally destroyed. As a result of the war, 56 percent had left their community to take refuge in other places (49 percent in Pakistan, 1 percent in Iran, and 6 percent in other parts of Afghanistan) for an average of 1.5 years. Of those who had left, 60 percent stayed for a period of between 6 months and 1 year. However, many had returned to their home village during the last year, mostly within the last 3 or 4 months. While staying in the camps they had paid frequent visits to their former homes and had worked their fields there. (The typical refugee came from an area close to the border.)

Respondents reported the average size of their land-holdings at 26.5 jeribs (8 percent own no land—a tiny fraction, considering that half the respondents live in a semi-urban environment) of which 17 percent is not irrigated and 14 percent is entirely irrigated, with the remainder partly to mostly irrigated.

Of the major agricultural problems encountered by the respondents, 10 percent found their fields destroyed and 14 percent had their irrigation systems destroyed; 29 percent lacked agricultural tools and fertilizers (12 percent) and pesticides (3 percent); and 20 percent needed improved seeds. Only 1 percent reported no agricultural problems.

The current occupation of the household heads was as follows: 29 percent were farmers, and 15 percent were landlords. Others were businessmen (18 percent) and teachers (16 percent). The jobs held by respondents who were not head of their household were farmers (14 percent), businessmen (10 percent), *mujahidiin* (7 percent), and students (42 percent). Respondents who were gainfully employed earned on average Afs. 61,500 per month.

Respondents held the following positions within their community: 9 percent elders, 5 percent mullahs, 8 percent commanders, and 11 percent *shura* members.

As major communal problems, respondents listed general health problems (32 percent), economic problems (15 percent), unemployment (2 percent), destruction of houses (17 percent), lack of food (14 percent), lack of security (4 percent), and lack of schools (6 percent). The most common problems among youth listed were unemployment (42 percent), illiteracy (18 percent), economic problems (20 percent), and communal disharmony (10 percent).

Sixty-seven percent of respondents saw health problems as very serious, and the other respondents viewed them as somewhat serious. Illiteracy was seen as very serious by 62 percent, with the rest defining it as somewhat serious. Unemployment was seen as very serious by the vast majority (90 percent), and the remainder viewed it as somewhat serious.

### **DISTINCTIONS BETWEEN THE SURVEY GROUPS**

Surveys, particularly about sensitive subjects like illicit drugs, are notoriously inaccurate, even more so in societies like Afghanistan. In addition, the NACP survey and NBAS were limited by resource and time constraints, as well as by political circumstances that impeded their implementation. The NACP survey had to be limited to the refugee camps because of the war, and the NBAS could not survey all intended areas or find enough addicts and health workers for that portion of the survey because of continuing civil strife. Nevertheless, both surveys are still valuable databases confirming most of our tentative conclusions.

The NACP sample in the camps covered 0.6 percent of all households and the NBAS survey inside Afghanistan covered communities housing 0.5 percent of the total population of the six provinces surveyed.

The NACP camp sample consisted of a universe larger than that of the NBAS sample. NACP respondents came from a majority of provinces, who, at the time of the survey, were living in 35 refugee camps in NWFP and Balochistan, and were mostly uneducated farmers.

The NBAS sample was intended to complement the NACP, including the hitherto "closed" urban communities, which were inaccessible last year.

The NACP sample was designed to be representative of rural Afghanistan as a whole, whereas the NBAS was designed to pick up certain critical strata, such as local leaders, health workers, and addicts. Thus, in contrast to the Afghan population, the NBAS population was 80 percent literate.

## 4. Attitudes

### OVERALL FINDINGS

The first section of this chapter presents the overall results of survey respondents' attitudes toward drugs. This discussion is followed by an explanation of how the results differed for particular sectors of respondents—especially among inhabitants of poppy- and nonpoppy-growing regions, informal leaders, refugees and nonrefugees, and poppy growers. Some data from these surveys are also used in the ensuing sections on the use of narcotics and media. However, the use data depend more heavily on the survey of health professionals and addicts in the six treatment units in Peshawar, Pakistan, that have a predominantly Afghan clientele; the media data rely heavily on secondary data.

#### Knowledge

Almost all Afghans reported that they were familiar with opium and three out of four with heroin—a relative newcomer to the Afghan scene. Although only a small fraction reported that tobacco and charas would render their users incapable of working, about 40 percent NBAS respondents reported the same for opium and 70 percent of NBAS respondents (80 percent of NACP respondents) for heroin.

The vast majority of NBAS respondents knew that heroin was made from poppy, and almost all knew the methods used in consuming the drug. Practically all knew about cannabis and poppy cultivation in Afghanistan. The NACP survey showed similar results. In short, Afghans are well informed about heroin and about their more traditional drugs (opium, hashish, bhang).

#### Attitudes

In the NBAS, Afghans were presented with a list of drugs [hashish, bhang (marijuana), cigarettes, naswar, opium, heroin, and alcohol] and asked to rate the harmfulness of each. Heroin was judged to be the most harmful drug by 45 percent of the NBAS respondents, second most harmful by 22 percent, and third by 12 percent. Of NACP respondents, 73 percent judged heroin to be the most harmful drug. Seventy-nine percent of NBAS respondents judged heroin to be among the three most harmful drugs. Opium was included among the three most harmful drugs by 93 percent, followed by alcohol (87 percent). Charas followed heroin with 33 percent, and cigarettes and bhang were barely mentioned.

In the NACP survey, 96 percent included heroin among the three most harmful drugs, 70 percent included opium, 60 percent alcohol, and 70 percent charas.

#### *Attitudes Toward Cultivation of Poppies*

More NBAS respondents (64 percent) were opposed to cultivation of poppies than were in favor of it (36 percent). Among NACP respondents, 55 percent were opposed, and 45 percent were in favor. Of all NBAS respondents expressing an opinion (either positive or negative), 24 percent viewed poppy cultivation as a violation of Islam, 18 percent said it was destructive of human health, and 16 percent

said it had other negative secular impacts. Supporters of cultivation argued that farmers needed income and that poppy cultivation was a legitimate way to secure it.

NBAS respondents expressed the following opinions on poppy cultivation: that it should not be permitted (63 percent); that it should be permitted only if needed to secure survival of the grower (23 percent); and that it is a cash crop like wheat (14 percent).

### ***Attitude Toward Drug Use***

NBAS respondents were asked whether it was all right to use various drugs (using the categories "very much so," "not quite all right," "not all right," and "not all right at all"). For opium, 86 percent responded that use was not all right at all, and the remaining 14 percent said that it was either not all right or not quite all right. Ninety-four percent said that heroin use was not all right at all, and the other 6 percent that it was not all right. For charas use, the responses were divided almost equally among not quite all right, not all right, and not all right at all.

### ***Drug Use Perceived as Problem for Afghans***

NBAS respondents were asked to characterize use of various drugs as a current problem for Afghans. For heroin, approximately 40 percent of respondents characterized it as a major problem and another 40 percent as a very great problem. Only 8 percent saw heroin use as no problem. Opium use was seen as less of a problem: 28 percent saw it as a very great problem, 30 percent as a major problem, 24 percent as a minor problem, and 17 percent as no problem. As might be expected, charas use was seen as even less of a problem than opium use: only 3 percent characterized it as a very great problem, 18 percent as a major problem, 38 percent as a minor problem, and 41 percent as no problem at all. Use of tobacco was overwhelmingly seen as either no problem or a minor problem.

### ***Attitudes Toward Reduction of Drug Problems***

Almost all respondents believed that action should be taken to prevent drug use and production as well as to help drug dependents.

### ***Attitude Toward Those Involved with Drugs***

In the NBAS, drug users were viewed as "bad" persons by 86 percent; dealers fared slightly better (83 percent said they were bad persons); and producers were seen in an altogether better light (72 percent "bad," 27 percent "neither good nor bad," 1 percent "good"). Among NACP respondents, 96 percent saw drug users as bad, and 88 percent saw drug dealers as bad. That is, respondents were more critical of users than of producers or even of dealers.

### ***Awareness of Islamic Injunctions against Narcotics***

On the position of Islam toward drugs, NACP and NBAS respondents were unanimous: Islam prohibits use of hashish, bhang, tobacco, alcohol, opium, and heroin. Cultivation of neither cannabis nor poppy is permitted. A closer look reveals that among the poppy-growing population (divided between respondents who report that poppies are grown in their village and those who confess that they grow it themselves), the percentage of those who spontaneously cited Islamic injunctions was considerably lower than among others.

## SECTORAL FINDINGS AND ANALYSIS

### Demographic Factors

The sample was segmented according to age, education, and occupation to observe any differences in awareness and attitudes.

The older the respondents were, the less opposed they were to cannabis and poppy cultivation. The more educated the respondents were, the more they took positions against cannabis and, in particular, poppy cultivation. Older respondents and less educated respondents were opposed to narcotics cultivation because they regarded producing these crops to be against Islam; for the younger and the more educated the main issue was the secular effects of narcotics production on public health.

The youngest and the oldest respondents were more likely than those of the middle age brackets not to know a heroin user; the more educated respondents were more likely to know heroin users. Farmers knew the fewest heroin users.

In their attitudes toward drug users, dealers, and producers, respondents were more lenient with advancing age and advanced education. The oldest group and farmers were the most lenient toward producers. The younger, the more educated, and non-farmers were more concerned than their opposites about drug abuse and poppy cultivation.

As to interest in dealing with drug abuse, teachers and those with higher education were most interested in prevention of drug use; elders were more interested in rehabilitation.

### Geographic Factors

#### *Attitude Differences by Province*

NBAS respondents were presented with a list of six drugs (charas, bhang, cigarettes, heroin, opium, and alcohol) and asked to rank the first, second, and third most harmful. The results for opium are shown in Table 1. Respondents in Kabul, Helmand, and Qandahar found opium more harmful than respondents in Wardak, Ghazni, and Nangarhar. Although respondents in the poppy-growing areas of Helmand and Qandahar might be expected to be more familiar with opium, residents in the other major growing area surveyed, Nangarhar, did not consider opium so harmful.

**Table 1. Percentage of Respondents Considering Opium a Harmful Drug, by Province**

Province	Most Harmful Drug	Second Most Harmful Drug	Third Most Harmful Drug
Kabul	42	50	8
Wardak	4	72	20
Ghazni	14	32	14
Nangarhar	2	68	26
Helmand	34	40	12
Qandahar	40	42	24



When the respondents are divided into rural and urban categories (Table 2), urban residents considered opium more harmful than rural residents.

**Table 2. Percentage of Respondents Considering Opium a Harmful Drug, by Type of Population**

Location	Most Harmful Drug	Second Most Harmful Drug	Third Most Harmful Drug
Rural	22	53	20
Urban	34	45	10
All	29	49	15

The consensus on the harmfulness of heroin was quite high in all surveyed provinces except Kabul (Table 3). In the five provinces rating harmfulness, at least 60 percent of respondents listed it as the first or second most harmful drug. In Helmand, 86 percent rated heroin first or second most harmful. By contrast, only 8 percent of Kabul respondents ranked heroin in the first two categories, and an additional 14 percent listed it as third most harmful.

**Table 3. Percentage of Respondents Considering Heroin a Harmful Drug, by Province**

Province	Most Harmful Drug	Second Most Harmful Drug	Third Most Harmful Drug
Kabul	48	18	14
Wardak	40	20	32
Ghazni	56	8	4
Nangarhar	52	10	6
Helmand	38	48	8
Qandahar	38	36	10

The rural-urban distribution shows the same pattern as that exhibited in the provincial distribution. As presented in Table 4, rural respondents considered heroin more harmful than did urban respondents.

**Table 4. Percentage of Respondents Considering Heroin a Harmful Drug, by Type of Population**

Location	Most Harmful Drug	Second Most Harmful Drug	Third Most Harmful Drug
Rural	42	30	13
Urban	49	14	11
All	45	22	11

Because alcohol is a prominent taboo in Islam, the results are interesting to examine. The provincial distribution, shown in Table 5, does not show as strong a pattern as that for heroin. Kabul had the lowest percentage of respondents ranking alcohol in the two most harmful categories. This might be consistent with one's expectations of the attitudes of people in the largest metropolitan area in Afghanistan, however, when rankings for alcohol as first, second, or third most harmful are examined, Qandahar has even lower percentages of negative respondents than Kabul. Wardak, Ghazni, and Nangarhar had the highest percentage of respondents listing alcohol as one of the three most harmful drugs.

**Table 5. Percentage of Respondents Considering Alcohol a Harmful Drug, by Province**

Province	Most Harmful Drug	Second Most Harmful Drug	Third Most Harmful Drug
Kabul	12	13	66
Wardak	60	8	36
Ghazni	28	48	22
Nangarhar	42	16	38
Helmand	22	10	46
Qandahar	18	14	24

The rural-urban distribution (Table 6) shows a pattern similar to the provincial distribution. When only the two most harmful categories are considered, rural respondents ranked alcohol more harmful; however, considering the three most harmful categories, urban respondents listed alcohol as more harmful.

**Table 6. Percentage of Respondents Considering Alcohol a Harmful Drug, by Type of Population**

Location	Most Harmful Drug	Second Most Harmful Drug	Third Most Harmful Drug
Rural	32	13	36
Urban	16	23	54
All	24	18	45

Respondents were asked to rank each of four problems (health problems, illiteracy, drug problems, and unemployment) as great, small, or none (Table 7). Five provinces showed roughly similar responses, with the smallest percentage indicating the drug problem as great, a large percentage (between 72 percent and 92 percent) indicating that it was a small problem, and a small percentage (ranging up to 28 percent) indicating it was no problem. Kabul's respondents consider drugs to be even less of a problem than do those in the other five provinces: 1 percent saw it as a great problem, 32 percent as a small problem, and 67 percent as no problem.

**Table 7. Respondents' Indications of Seriousness of the Drug Problem, by Province (percent)**

Province	Great Problem	Small Problem	No Problem
Kabul	1	32	67
Wardak	20	76	8
Ghazni	2	76	22
Nangarhar	0	72	28
Helmand	6	82	12
Qandahar	6	92	2

Rural respondents consider drugs to be more of a problem than do urban respondents (Table 8), although only a very small percentage in either category indicated the drug problem as great. The percentage of urban respondents indicating that drugs were not a problem was four times larger than the corresponding percentage of rural respondents.

**Table 8. Respondents' Indications of Seriousness of the Drug Problem, by Type of Population**

Location	Great Problem	Small Problem	No Problem
Rural	6	81	13
Urban	1	44	55
All	4	62	34

Respondents were asked whether it was "all right" to use various drugs. As shown in Table 9, respondents from all provinces surveyed believed that heroin use was not all right. Fewer respondents from opium-growing areas (Nangarhar, Helmand, and Qandahar) said that opium use was not all right at all. For charas, respondents in the nonpoppy-growing provinces of Wardak and Ghazni (but not in Kabul) responded in higher numbers that heroin use was not all right at all than did respondents in the three poppy-growing provinces.

Table 10 shows the respondents divided into rural and urban categories. Both groups said that heroin use was not all right at all, but a lower percentage thought the same about charas. For opium use, a larger percentage of urban respondents indicated that it was not all right at all than did rural respondents.

Respondents were asked their opinions of drug producers (Table 11). Except for Helmand (4 percent), there were no positive responses. The provincial distribution of neutral and negative responses did not break cleanly into poppy-growing and nonpoppy-growing provinces. Neutral responses for Ghazni, Nangarhar, and Helmand were lower (in the low 20 percent range) than for Kabul, Wardak, and Qandahar (from 28 to 38 percent). Negative responses were higher for Ghazni, Nangarhar, and Helmand (in the 76 to 78 percent range) than for Kabul, Wardak, and Qandahar (62 to 72 percent range).

**Table 9. Percentage Indicating Use of Various Drugs as "Not All Right at All," by Province**

Province	Heroin	Opium	Charas
Kabul	95	90	8
Wardak	100	100	76
Ghazni	100	98	72
Nangarhar	86	78	46
Helmand	92	66	2
Qandahar	94	84	48

**Table 10. Percentage Indicating Use of Various Drugs as Totally Unacceptable, by Type of Population**

Location	Heroin	Opium	Charas
Rural	90	79	38
Urban	96	92	25
All	94	86	32

**Table 11. Attitudes Toward Drug Producers, by Province (percent)**

Province	Positive	Neutral	Negative
Kabul	0	28	72
Wardak	0	36	64
Ghazni	0	22	78
Nangarhar	0	24	76
Helmand	4	20	76
Qandahar	0	38	62

### ***Other Differentiation of Responses***

#### ***Attitudes in Areas Until Recently Under Kabul Regime Control versus Areas Under Mujahidiin Control***

The NBAS areas in the sample where the Kabul regime lost control only recently are Kabul and Ghazni. Unfortunately, these are the only two semi-urban areas of the sample. Hence, differences observed might be due more to the different lifestyles and access to education, diversification into nonagricultural jobs, and exposure to mass media than to the effects of communist control.

#### ***Attitudes of Ex-Refugees versus Those Staying Inside Afghanistan***

For the most part, the most striking differences are visible in the previous discussion citing findings from both surveys. In this subsection we concentrate on the differences in the NBAS and divide the respondents into those who did not leave their homes (45 percent), those who took refuge somewhere in Afghanistan (4 percent), those who went to NWFP in Pakistan (31 percent), and those who went to Balochistan in Pakistan (18 percent).

Table 12 shows the relationship between the respondents' refugee status and their perceptions of the seriousness of the drug problem. Only small percentages (not more than 8 percent) of each group ranked drugs as a great problem. Respondents who were not refugees perceive drugs to be less of a problem than do the other respondents. Those who were refugees in Afghanistan and Balochistan believed it to be more of a problem than the other respondents.

**Table 12. Seriousness of the Drug Problem, by Refugee Status  
(percent)**

Refugee Status	Great Problem	Small Problem	No Problem
Not refugee	6	52	43
Refugee in Afghanistan	8	75	17
Refugee in NWFP	1	63	36
Refugee in Balochistan	2	86	12

Heroin was identified as the most harmful drug by those who went to the NWFP and those who stayed in other parts of Afghanistan. Those who stayed behind saw heroin as less of a problem. All respondents were, however, unanimous about the total unacceptability of heroin use. Refugees in NWFP and Balochistan indicated a greater awareness of heroin use than the other groups. Nonrefugees showed the least awareness (Table 13).

**Table 13. Heroin Use Among Afghans, by Refugee Status (percent)**

Refugee Status	No Use	Some Use	Know Users
Not refugee	39	55	6
Refugee in Afghanistan	23	77	0
Refugee in NWFP	21	64	15
Refugee in Balochistan	32	59	10

### *Attitudes of Informal Leaders*

As the molders of public opinion, informal leaders play an important part in awareness campaigns and other antidrug programs. Therefore, NBAS singled out the views of informal leaders and presents them in greater detail. Informal leaders represent half of the universe covered by the NBAS. They were composed of elders (9 percent), mullahs (5 percent), commanders (8 percent), *shura* members (11 percent), and landlords (18 percent). All the informal leaders (except 11 percent of the mullahs) owned land; elders and landlords were among those with the most land. As to the perceived seriousness of drug abuse, *shura* members saw it as least serious, 44 percent of commanders thought it a serious problem, followed by landlords. Elders and mullahs were comparatively more concerned.

Elders selected opium as the most dangerous drug; landlords and mullahs, alcohol; and commanders (71 percent) and *shura* members, heroin. As to local availability of drugs, landlords and mullahs knew the least about availability of charas and opium. Only a few landlords knew about the availability of heroin.

Mullahs were most concerned about the adverse effects of drug use on the user; some saw it as difficult even for naswar users to perform work, not to mention users of charas, opium, and heroin. *Shura* members (63 percent) and landlords (65 percent) thought it impossible for heroin users to perform work. Mullahs (94 percent) and elders (81 percent) were most pessimistic about work potential of heroin users.

Opium use was seen as a major problem by almost all mullahs, but only by half or fewer than half of elders and landlords. Whereas most other informal leaders saw heroin use as a major problem, only two-thirds of the landlords shared this view. Use of drugs, particularly opium and heroin, was totally unacceptable to all informal leaders, with the landlords and elders (some of whom, incidentally, were also landlords) least opposed.

Landlords were the informal leaders most positive toward cannabis cultivation (70 percent, with 58 percent basing their opinions on the farmers' need for income), whereas mullahs were the most opposed (90 percent). For informal leaders as a whole 64 percent were opposed, with 67 percent stating that growing cannabis was a violation of Islam. The relative attitudes toward poppy cultivation had a similar distribution, but the percentage generally opposed was higher.

Landlords were also the biggest advocates of growing poppy. For 35 percent growing poppy was like growing wheat, and an additional third thought poppy growing permissible to secure survival. Almost all mullahs opposed these views. The commanders were the next most opposed group.

Commanders and *shura* members generally stated that heroin had become an Afghan problem, whereas mullahs and landlords disagreed. Mullahs and landlords perceived no change in heroin problems within the last 2 years; some commanders and *shura* members had noticed an increase.

Mullahs and *shura* members saw a decrease in or no heroin problems. Commanders were the only group in which no one stated that there was a heroin problem, a view held by 30 percent of landlords.

Landlords professed the lowest personal knowledge about drug users: 30 percent knew no charas user, 83 percent knew no opium user, and 97 percent knew no heroin user, whereas 20 percent of the *shura* members knew of at least one heroin user. Commanders had a high knowledge of drug users: only 11 percent knew no charas user; 57 percent, no opium user; and 54 percent, no heroin user.

All groups had negative attitudes toward drug addicts. They were seen as "bad" people by 94 percent of mullahs and *shura* members, 89 percent of commanders, and 82 percent of landlords. All mullahs saw dealers as bad, a view shared by 71 percent of the landlords. Producers again attracted the wrath of the mullahs: all saw them as bad. Landlords were most lenient (46 percent), followed by 70 percent of elders (there is some overlap in the composition of these two groups).

When asked how to help drug dependents, landlords and mullahs were equally tough, with 44 percent choosing to arrest and punish drug users. Only a low percentage of elders and landlords were in favor of providing treatment; mullahs and commanders were more supportive.

To prevent drug abuse, *shura* members suggested providing jobs (40 percent), versus 12 percent of landlords supporting such an approach. Mullahs and commanders (61 and 57 percent, respectively) proposed education and awareness promotion; elders and *shura* members were generally opposed.

When asked how to prevent drug production, commanders were the first, followed by *shura* members, landlords, and elders, in proposing agro-economic assistance (highest 75 percent, lowest 61 percent); mullahs did not favor assistance (22 percent). The mullahs (33 percent) expected the new Islamic government to prevent drug production, a view not shared by landlords (15 percent).

Mullahs were also the most vocal (89 percent) in supporting the growth of alternative crops, followed by commanders (54 percent). *Shura* members and landlords were less in favor of alternative crops (37 and 38 percent, respectively). Most landlords were opposed to promoting alternative crops.

Landlords were not much concerned about drug issues in general. Fifty-nine percent expressed no concern, and only 12 percent expressed great concern over drug abuse. All mullahs were concerned—44 percent of them greatly so. Commanders were even more concerned than mullahs (57 percent). About poppy cultivation, most landlords had no concern (64 percent), with merely 12 percent being greatly concerned. Again, mullahs (75 percent) and commanders (50 percent) were most concerned. However, all groups except landlords were more concerned about poppy production than about drug abuse (Table 14).

**Table 14. Position in Community and Level of Concern About Drug Issues**

Position in Community	Percentage of Respondents Indicating			
	No Concern About Drug Abuse	Great Concern About Drug Abuse	No Concern About Poppy Cultivation	Concern About Poppy Cultivation
Elder	24	30	27	33
Mullah	0	44	0	50
Commander	0	57	0	75
Shura	5	34	5	32
Landlord	59	12	64	12
No Position	22	28	21	37



Landlords showed the least interest in receiving information on drug issues; 35 percent were not interested and merely 8 percent expressed "great" interest. All commanders and *shura* members were interested, with a majority (61 percent and 51 percent, respectively) expressing "great" interest. In specific drug-related areas of interest, mullahs were most interested in prevention issues (67 percent), commanders in rehabilitation (57 percent), and landlords in production (12 percent) and consumption issues (15 percent).

### *Attitudes of Poppy Growers*

Poppy cultivators held the following occupations: 59 percent farmers; 18 percent businesspeople; 10 percent landlords (with no other occupation); and 4 percent each teacher, *mujahidiin*, and unemployed. Five percent own land between 2.5 and 5 jeribs, 20 percent between 5 and 10 jeribs, 38 percent between 10 and 25 jeribs, and 28 percent more than 25 jeribs, or an average of 18.95 jeribs (12.6 for nonpoppy growers and 13.3 jeribs for all respondents). This indicates that poppy growers in our rural sample are not the poorest segment of population. Poppy growers use 1.9 jeribs (or just 5 percent of their total land, on average) for growing poppy. Only 10 percent have no irrigation, and another 10 percent have all their land irrigated, whereas 64 percent have part of their land and 13 percent most of their land irrigated.

About 38 percent of poppy cultivators have no position in their community; the rest are either elders (10 percent), *shura* members (8 percent), or landlords (44 percent). For respondents as a whole, landlords represent merely 18 percent of the total. All poppy cultivators are Pashtuns. The cultivators have a lower education level than nongrowers, with 51 percent (25 percent of all respondents) being illiterate and only 10 percent (21 percent of all respondents) having received higher education. In 38 percent (13 percent of all respondents) of their households nobody can read, only 3 percent watch television, and 44 percent (27 percent of all respondents) have no radio. Growers are generally less accessible to media than nongrowers. Poppy growers prefer VOA (28 percent) over BBC (23 percent), while other respondents prefer BBC to VOA by a margin of two to one.

Poppy growers view drug abuse as more serious than nongrowers. Eight percent (3 percent of total respondents) view drug addiction as a very serious problem, and 74 percent (61 percent of total) as somewhat serious. Heroin (30 percent) is seen as second to opium (34 percent) as the most harmful drug, whereas for nongrowers heroin (47 percent) comes first and opium receives less attention (28 percent). As first, second, and third most harmful drug, opium received the most responses (100 percent), followed by heroin (82 percent). However, growers see opium dependency as less of a problem in one's ability to work than other respondents (18 percent believe it will cause no problem, a view shared by only 2 percent of the nongrowers). For heroin, growers and nongrowers share a realistic assessment (64 percent of growers and 70 percent nongrowers say it is impossible to perform a job while dependent on heroin).

Poppy growers do not rank economic problems high on their list of problems: 15 percent list them as their first choice and only 3 percent as their second choice. (Other respondents showed 15 percent each for first and second choices.)

Sixty-seven percent of poppy growers (versus 57 percent of nongrowers) saw opium use as a major or great problem, as did 77 percent (versus 80 percent) for heroin. Overall, poppy growers were, however, more tolerant of charas use than others: only 15 percent (34 percent for nongrowers) found it totally unacceptable. The margin was smaller for opium and heroin: 72 percent versus 88 percent for opium, and 90 percent versus 95 percent for heroin. As to reporting local discussions over drug problems, poppy growers were quite reluctant to openly discuss such matters: only 8 percent (versus 33 percent for nongrowers) mentioned frequent discussions, while 75 percent (43 percent) have had discussions on heroin.

Poppy growers were less aware of heroin use. Not a single poppy grower reported knowing a heroin user (10 percent of all respondents knew one). Only 3 percent (versus 5 percent of all respondents) believed heroin use had already become an Afghan problem, and just 9 percent (17 percent of nongrowers) said it certainly will become one; 44 percent (26 percent of nongrowers) maintained it never will be one.

Within poppy-growing villages, 57 percent of respondents did not grow poppy, and 43 percent did. Eighty percent of these growers reported cannabis cultivation in their community, as well, and 33 percent of the poppy growers also grow cannabis. Interestingly enough, the poppy growers grow more cannabis than those who cultivate only cannabis: 0.45 jerib compared with 0.4 jerib on average.

When asked their justification for growing poppy, 41 percent of growers (11 percent of nongrowers) mentioned that poppy was like wheat, that is, grown for income. Another 51 percent (19 percent of nongrowers) said that poppy should be grown only to secure "survival." As it is, 92 percent (30 percent of nongrowers) see poppy cultivation as justified under the prevailing conditions. Clearly, economic conditions are extremely important factors. The differences between growers' and nongrowers' attitudes, as expected, are substantial.

The views of growers and nongrowers about what measures could be taken to prevent production of drugs (poppy cultivation) are shown in Table 15. The options with the highest percentages are agro-economic assistance and the prevention of production by the *mujahidiin* government. There is little difference in the responses of growers and nongrowers.

Ninety-two percent of growers (98 percent of nongrowers) supported the desirability of preventing drug production. Poppy growers were less interested than other groups in receiving drug information: 54 percent (8 percent of nongrowers) professed no interest, with 31 percent (48 percent) expressing some interest and merely 15 percent (44 percent) expressing great interest.

**Table 15. Means of Preventing Drug Production**

	Percentage of Respondents Choosing							Other
	Agro-Economic Assistance	Providing Jobs	Prohibiting Cultivation	Destroying Fields	Punishing Producers	Islamic Injunctions	Mujahidiin Government Prevention	
Poppy Growers	62	3	5	5	3	5	15	3
Nonpoppy Growers	59	1	5	4	1	3	21	5
Total	59	1	5	4	1	4	21	5

### COMPARISON OF NACP SURVEY AND NBAS

The refugees living in Pakistan were exposed to the heroin epidemic there. This experience is clearly reflected in their responses: they know much more about heroin and its dangers, they know more Afghans who are addicted to heroin, and they are less optimistic that their country can be spared a similar epidemic.

As the NACP survey was concentrated on refugees from rural areas and not focused on the "elite" as the NBAS was, the NACP survey respondents' answers on agricultural and poppy cultivation issues deserve special attention. The respondents to the NACP survey clearly seemed less ready to forgo the

financial advantages of poppy production. They gave fewer indications of being ready to stop production, whereas the respondents to the NBAS were more adverse to poppy cultivation.

### COMMUNITY NARCOTICS PROFILES

The responses received from directly interviewing Afghans can be contrasted with background information on narcotics-related matters in their communities that was collected by the field investigators. The community profiles collected during this survey contain some of the information received concerning community demographic data, infrastructure, the agricultural sector, and the political and economic sectors.

The most obvious discrepancies between these data and those from the overall survey appear in the data on drug use reported from the poppy-growing communities; drug use, even of opium and heroin, is much more prevalent than reported. If we are to believe the community profiles, there are more people involved in growing poppy than the survey reveals (with NBAS respondents reporting that 43 percent of farmers grow poppy in the poppy-growing communities). There could have also been some underreporting of land under poppy cultivation. According to the statements in the community profiles, the average holding might be more than 2.59 jeribs (1 jerib = 0.483 acre) and not, as reported in the survey, 1.97 jeribs.

Little opposition to drug production was reported from local leaders in the surveyed districts. The data received from these profiles are particularly striking because cannabis cultivation could be much greater than expected and, for some communities at least, could be cultivated together with poppy. The income derived from cannabis could well be between one-third and two-fifths that from poppy.

## 5. Narcotics Use

A number of attempts have been made both inside Afghanistan and in refugee camps across the border in Pakistan to gather data about narcotics use.

In 1986, Dr. Khalid Mufti conducted a survey in Kacha Garhi Camp No. 1 near Peshawar, Pakistan, to study drug abuse patterns among Afghans. This study is often quoted because it was the first conducted on Afghan refugees. Dr. Mufti gathered data on the demographics of Afghan drug addicts, their pattern of drug use, age at first use, manner of use (smoking or injection), effect of drug use on marital relationships (a euphemism for "sexual potency") and health, and motivation to seek detoxification in hospitals. However, because the study report did not discuss sample selection, we cannot guarantee its representativeness.

For example, although the study concluded that 22.5 percent of the surveyed individuals were heroin abusers, we cannot confirm whether the percentage of heroin addicts in the general population is similar. No information was provided on how the study respondents were selected; we assume that they were identified by word of mouth. The respondents were addicted to cannabis, heroin, opium, alcohol, bhang, and sedatives and tranquilizers.

Despite issues of sample selection, the survey results indicated that the majority of cannabis, opium, and bhang abusers were from rural areas, whereas abusers of heroin, tranquilizers, and alcohol were more likely to come from urban areas. The majority of cannabis and heroin abusers were in the 16-to-25 age group. Heroin abusers came from higher income groups; cannabis and opium abusers came from middle income groups; and bhang abusers came from lower income groups. Regardless of the drug, however, the overwhelming majority used it every day. For example, 90 percent of heroin abusers used heroin daily. One person injected heroin and another sniffed it; the rest smoked it.

The NBAS was designed to obtain direct data on narcotics use. Unfortunately, the design of the survey conflicted with the political reality in Afghanistan. First, the interviewers did not have enough time to collect data from all the identified groups of respondents. Second, hospital closures because of civil strife eliminated possibilities of interviewing the targeted number of health workers. Third, physical dangers experienced by interviewers in Afghanistan prevented them from reaching some of the originally selected geographic areas, especially in the north of Afghanistan. These difficulties especially had an impact on the drug user and health worker surveys. The data collectors were successful in completing 358 attitude questionnaires from the general population, but only 9 from health workers—none of whom worked in a treatment unit—and 12 from addicts (four to heroin, six to charas, one to opium, and one to sedatives). An alternative strategy was quickly devised to gather ethnographic data in Peshawar from treatment unit directors, heroin addicts, and health workers who work with Afghans. Consequently, we interviewed directors of the six treatment units, seven Afghan heroin addicts, and six health workers.

The number of respondents for some components of the study was very small; therefore, definite conclusions based on the survey results must take that number in consideration. Unfortunately, because the unit directors, the health workers, and patients we interviewed in Peshawar were not randomly selected, they may or may not be representative of the total population of these groups. In addition, because we were not able to interview all the scheduled users and health workers inside Afghanistan, we ended up with a relatively small number of respondents. Here again, the reader must take into consideration these small numbers in interpreting the survey results. The best approach is to use them

as a means of enhancing our understanding of the addiction problem, and to consider that before implementing programs, another attempt should be made at completing the collection of data and strengthening the conclusions drawn here.

## ESTIMATES OF NARCOTICS USE BY VARIOUS SEGMENTS

### Health Workers

Everyone interviewed in Peshawar agreed that heroin addiction is prevalent among Afghans, especially in the region around Peshawar. Heroin is easily available and can be obtained from inside Afghanistan or from the tribal areas of Pakistan (just across the border),<sup>1</sup> or purchased from shops on one of the main streets of Peshawar. The majority of the health workers (four of the six) in Peshawar listed drug addiction as a major health problem among Afghans; the other two listed it secondary to chest diseases and lack of medical facilities. In contrast, none of the health workers inside Afghanistan mentioned drug addiction as a health problem. Rather, their major concern was lack of medications (56 percent), followed by lack of other medical facilities (33 percent). Malaria and diarrhea were mentioned once by each of two medical doctors. This is not surprising considering the political situation, their immediate medical needs, and the small number of addicts they treat, as discussed below.

All the treatment unit directors agreed that the narcotics problem is more serious among Pakistanis (an estimated 1.2 million heroin addicts) than officially estimated and that it exists in similar proportions among the Afghans.<sup>2</sup> Specifically, the unit directors reported that more than 50 percent of Afghans use charas; one thought about 80 percent did. Four estimated that anywhere between 5 and 20 percent were addicted to opium and between 8 and 10 percent were addicted to heroin. Both Afghan health workers we interviewed at the Nejat Centre thought that heroin addiction among Afghans reached 20 percent. These figures seem incredibly high and clearly respond to the situation in which treatment people find themselves.

To arrive at an estimate of prevalence of drug use, health workers inside Afghanistan were also asked to estimate the number of drug abusers they see in their medical practice. Of the nine respondents, seven (78 percent) had treated drug users during the past 12 months; however, the overwhelming majority of their patients were addicted to charas and a little more than a third to opium; none was addicted to heroin. Because the total number we interviewed was very small, we highly recommend that this particular population be targeted for future surveys. We believe that in the absence of addiction treatment units, health workers are an excellent source for estimating future drug abuse in Afghanistan.

Treatment unit directors were not specifically asked the average age of clients. Those who provided this information indicated that it is between 20 and 35 years. Very few patients were under 20. This was verified by the data we collected from the clients as discussed below. One health worker reported that opium addicts tended to be older—over 40.

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<sup>1</sup>The tribal areas are located in the Northwest Frontier Province (NWFP) bordering Afghanistan. Those areas have political autonomy, and local law enforcement cannot be applied there. Heroin is easily available to the Afghan refugees from those areas.

<sup>2</sup>A briefing paper produced by the Drug Abuse Prevention Resource Center (DAPRC) reported that the 1 million figure represents approximately 50 percent of the documented drug abusers in Pakistan, now known to be more than 2 million.

Unit directors and their health workers were also asked about the total number of Afghan clients they treated during the past 12 months—which should provide another means to estimate the prevalence of drug use. In the inpatient programs, a total of 569 Afghans had been treated for heroin addiction, and 2 to 8 were enrolled in the outpatient rehabilitation program. Adding the numbers of addicts on the waiting lists of these units gives some indication of the magnitude of the problem of addiction. As discussed in the next section, the waiting lists for the units we interviewed ranged from 1 to 6 months, with one unit, serving only Afghans, having 120 persons on its waiting list besides being booked for the remainder of the current year.

## **Treatment Population**

We asked the addicts we interviewed in the Peshawar treatment centers how many of their friends used heroin and how many heroin users in the community were known to them. Only one patient indicated that none of his friends used heroin, the others reported one to six friends. When asked how many people they knew in their community who used heroin, the patients' responses varied. One said "a lot," two said five or six, one said three or four, and two said more than 100. Although the respondents may have misunderstood the question—with some accounting for people in the community in general and others accounting for people in the community they knew personally—the numbers are still high.

A similar question was asked of the addicts interviewed inside Afghanistan. Although they were not in treatment units, we included their responses with our treatment population because they were identified users. Eleven of the 12 (92 percent) had friends who used drugs. Five had six to nine friends who used drugs, and four had three to five friends who were users. Unfortunately, the two sources cannot be adequately compared because the treatment population was asked about friends' heroin use, and the NBAS asked about friends' drug use in general, including heroin.

Age of first use is an important variable in estimating the problem for certain population groups, such as adolescents. Of the treatment population, only one patient had started using heroin at 18; the others started anywhere from 23 to 27 years of age. The patient starting at 18 had used heroin for only 2 years; the remaining patients were all hardcore users, their use ranging from 7 to 20 years. From the NBAS, we found that only four of the addicts were addicted to heroin and the first age of use was not different from the addicts in the treatment centers. The age of first use ranged from 23 to 28 years. Age of first use of opium and charas did not differ significantly from that of heroin. Charas users started slightly earlier than the others, their age of first use ranging from 21 to 28 years. The opium addict started when he was 24. This finding has ramifications for future educational and awareness campaigns.

These data may lead campaign developers to target the middle and senior high school-age populations with antinarcotics messages before their use of heroin in their early twenties. One must still consider, however, that most Afghans receive no secondary education and our only opportunity to educate them may be in the primary grades, if they go to school at all.

## **General Population**

The NBAS data gathered from nontreatment populations can be used to shed additional light on prevalence. Respondents were asked for the number of heroin users they knew. Although almost 21 percent said they knew one or two people who used heroin—which is a substantial number—the overwhelming majority, 78 percent, said they knew no one who used heroin. More than one-third of these respondents resided in Kabul (Table 16). The treatment unit population was not asked about

charas and opium use, whereas the NBAS respondents were. The results indicated that only a minority, 19 percent, knew no charas users, whereas the majority knew no opium users (73 percent) or heroin users (78 percent). Thirty-one percent knew one or two users of charas, and 13 percent and 21 percent knew one or two opium and heroin users, respectively. For charas, 19 percent knew three to five users, and 24 percent knew six to nine users. The percentages for these cells were very small for opium and heroin users (Tables 16–18).

**Table 16. Number of Heroin Users Known to Respondents**

Province	Number of Respondents Knowing No Users	Number of Respondents Knowing 1 or 2 Users	Number of Respondents Knowing 3 to 5 Users
Kabul	101	31	1
Wardak	20	5	—
Ghazni	47	3	—
Nangarhar	34	16	—
Helmand	40	10	—
Qandahar	38	10	2
Total	280	75	3
Percentage of Total	78.2	20.8	0.8

**Table 17. Number of Opium Users Known to Respondents**

Province	Number of Respondents Knowing						
	No Users	1 or 2 Users	3-5 Users	6-9 Users	10-19 Users	20-49 Users	50+ Users
Kabul	81	16	25	11	—	—	—
Wardak	25	—	—	—	—	—	—
Ghazni	50	—	—	—	—	—	—
Nangarhar	47	3	—	—	—	—	—
Helmand	30	17	2	1	—	—	—
Qandahar	28	9	3	3	5	2	—
Total	261	45	30	15	5	2	—
Percentage of Total	72.9	12.6	8.4	4.1	1.4	0.6	—



**Table 18. Number of Charas Users Known to Respondents**

Province	Number of Respondents Knowing						
	No Users	1 or 2 Users	3-5 Users	6-9 Users	10-19 Users	20-49 Users	50+ Users
Kabul	24	20	21	60	8	—	—
Wardak	5	12	3	4	3	—	—
Ghazni	17	20	11	2	—	—	—
Nangarhar	6	34	3	5	2	—	—
Helmand	9	16	18	5	2	—	—
Qandahar	8	9	12	9	3	1	8
Total	69	110	68	85	17	1	8
Percentage of Total	19.3	30.7	18.9	23.7	4.7	0.3	2.2

From all the numbers given above, one can conceivably arrive at rough estimates—though not purely scientific ones—of the magnitude of the problem among Afghans. First, if we took a conservative stand and considered the lowest percentage of addicts mentioned by unit directors (8 percent), of the 18 million Afghan population, there may conceivably be more than a million addicts. This number may be grossly inflated because health workers and unit directors are very close to the addiction problem and committed to convincing people how serious it is.

Second, based on the numbers provided by the survey of the treatment population, we assumed that the number treated in 1991 is a typical number of people in treatment (569 patients plus 5 in the rehabilitation program). To that we added the number of friends who use heroin (average of three friends each—taking the middle range of one to six friends), the number of heroin users in the community known to the patients (average of 30 persons for each patient), and the number of addicts on the waiting lists of the treatment units (a total of 745), to arrive at about 20,000 addicts.

Third, based on the percentage of individuals in the general population survey, we found that 21 percent said they knew one or two people who used heroin. If we assume that our respondents were representative of the male population (about 30 percent of the total population), and that each of them knew only *one* heroin user, it is possible that the total number of heroin users is 1,134,000 individuals. (We assumed that of the total population of 18 million, 5.4 million were adult males.) We reiterate that these numbers were arrived at only to provide a picture of the magnitude of the problem and that to arrive at more scientific numbers, more data must be gathered.

## CONSEQUENCES OF DRUG USE

### Physical Consequences

Drugs certainly had social and physical consequences for those who used them and were addicted to them. The treatment unit directors reported that the patients who came into their units were unhealthy and had not practiced good hygiene in a while. Although we did not collect specific data on co-morbidity, unit directors and their health workers in Peshawar reported a high incidence of upper

respiratory ailments, including tuberculosis, as well as stomach disorders. One unit reported that 71 percent of their patients were anemic. As a result, part of the treatment program is teaching addicts how to stay clean, clean their clothes and utensils, and regain their health by offering them nutritious food. Some units took photographs of patients before and after treatment that were later shown to the patients and to their families upon discharge. From our observation, all the patients had improved physically as a result of having been in treatment. In addition—and although no one else mentioned it—one of the unit directors reported to us that one of the motivating factors in bringing patients into treatment was sexual impotence.

The treatment population was also asked about the consequences of heroin use on health. Only one patient, who was 18 years old and had been an athlete, reported no physical consequences. All the others indicated that their health had greatly suffered. Data from the NBAS also indicated serious consequences of use to health. One of the 12 respondents said his health had "severely declined," five (42 percent) indicated their health had "greatly declined," and four (33 percent) said that their health "somewhat declined." Only two of the users (17 percent) said their drug use had no effect on their health.

### **Psychological Consequences**

Although none of the clients reported psychological consequences, one unit director believed that the men come into treatment because they have lost their self-respect. Self-respect is very important to the males in this culture, and they want to regain it. Another unit director reported that many of his patients are depressed and some suffer from major depression during and after treatment. He refers these patients to a psychiatric hospital.

### **Social Consequences**

#### ***Family and Marital Relationships***

Heroin also had devastating effects on family life. Our treatment respondents reported that heroin damaged or destroyed their families. One man told us that his marriage lasted only 1 year because of his addiction. Another said that his addiction "broke my relation with my wife and children," and a third said "my family hates me because I am addicted." Only 14 percent of respondents had no family problems as a result of his addiction. The NBAS also asked for influences on both family and marriage. As for family, 42 percent said their family life had "somewhat deteriorated," whereas 28 percent said drug use had "greatly deteriorated" their family life. Conversely, one-quarter of respondents experienced no change in their family relationships. When asked about the effect of drugs on their marital relationship, two had never been married, four reported their marital relationships had "greatly deteriorated," and three reported no change in those relationships; respondents were not asked how long they had been married.

#### ***Employment and Income***

The effect of heroin on employment and income was available from only a few respondents, because two were not employed and one was in school. However, three respondents (43 percent) said their income had been reduced as a result of their addiction. One respondent was a policeman whose income was not affected because he received heroin from sellers free. The NBAS respondents were almost evenly split between "no change" (50 percent) and "greatly decreased" (42 percent) when asked

about the influence of drugs on income. The 50 percent indicating "no change" also indicated that there was no change in their working capacity, but 25 percent of them said they could not perform any regular work as a result of the drug use. Seventeen percent reported their working capacity had "greatly increased." In the NBAS attitudes questionnaire, an overwhelming majority of respondents (70 percent) believed it impossible to take heroin and be able to work; the remaining 30 percent said it would be very difficult.

## 6. Media Accessibility

Afghanistan has limited media penetration. The two most important factors responsible for this are war damage and the poor economic status of the country. Afghanistan has one of the highest poverty and illiteracy rates in the world. Neither the means for supporting media, nor the education to use it, is widespread. Estimates of literacy are 12 percent. Fighting among *mujahidiin* factions since the fall of the communist government in Kabul has worsened the media situation. Media sources are generally confined to shortwave radio and limited newspaper distribution. However, if the fighting ends for a sustained period, it is likely that television stations and additional radio stations and newspapers will resume operation.

Among the informal leaders surveyed by the NBAS, most had received education, except the landlords, of whom 77 percent were illiterate. Hence, landlords lagged in their exposure to newspapers, whereas commanders and *shura* members read the most and watched television the most. They and elders also listened more to the radio. Landlords and mullahs were the least exposed to the media. Commanders were the group most exposed to films (21 percent), and *shura* members had often seen videos (10 percent). Commanders listened to radio programs (75 percent), whereas landlords had the lowest exposure to radio (14 percent). Commanders had noticed posters (25 percent) and read brochures (54 percent) and magazines (39 percent). Landlords were least exposed to these media. As to books (mostly religious books) mullahs were most exposed (78 percent) and landlords least (6 percent).

When asked which radio station they preferred, mullahs and landlords ranked BBC first, whereas elders, commanders, and *shura* members preferred Voice of America (VOA). Of the preferred type of radio program, all preferred news; only a few commanders and *shura* members would "venture" into listening to drama.

Poppy growers in general were less exposed than others to media: films were seen by a higher than average percentage—13 percent (9 percent of all NBAS respondents); however, all other media were used less than average: none (9 percent of all) viewed television, 3 percent (5 percent of all) viewed videos, 26 percent (48 percent of all) listened to radio, 4 percent (13 percent of all) noticed posters, 8 percent (23 percent and 14 percent of all, respectively) read books and magazines, 24 percent (38 percent of all) read a religious book, and 90 percent (97 percent of all) attended Friday sermons.

### NEWSPAPERS

Despite Afghanistan's high illiteracy rate, newspapers are widely accessible to Afghan households. The University of Nebraska/Omaha (UNO) reported in 1989 that at least a dozen newspapers were being published in Afghanistan. According to the NBAS, about two-thirds of the relatively elite households surveyed read newspapers occasionally. Of the remaining one-third of households, 13 percent had no people able to read and 21 percent simply did not read newspapers. The percentage of newspaper readers was substantially higher in Kabul than in the other five provinces surveyed. When asked which newspaper they read, almost half the respondents said they had no regular preference. The response with the second largest percentage was *Shahadat* (22 percent), which is published by Hezb-i-Islami. The other five newspapers receiving responses registered percentages of 11 percent or lower.

According to the NACP survey, almost half of all households did not read newspapers—because no one either could read them or had an interest in reading them. The other half of households read newspapers at least occasionally. *Shahadat*, with 21.6 percent of all respondents, and *Wahdat*, with 10.4 percent, were the most widely read newspapers. The much higher percentage of newspaper readers in the NBAS is explainable by the higher educational level of the NBAS population compared with that of the NACP population.

## RADIO

Radio broadcasts are one of the most accessible forms of media in Afghanistan. Radio's popularity was enhanced by the circumstances of the war. The communist slant of the former regime's programming caused Afghans to turn to foreign shortwave broadcasts for realistic news of events inside and outside Afghanistan. The communist government nevertheless expanded broadcasts in the Uzbek and Turkmen languages.

In addition to the communist government's broadcasts, the University of Nebraska at Omaha reported in 1989 that at least seven foreign radio stations broadcast in Afghan languages to Afghanistan and neighboring countries. These seven included the British Broadcasting Company (BBC), VOA, Deutsche-Welle, Radio Pakistan, Radio Tehran, All-India Radio, and Radio Beijing. A U.S. Information Agency (USIA) survey of Afghans in NWFP refugee camps in 1986 found that three-fourths had access to a radio and that many were regular listeners (Kielpinski 1986, in UNO 1989). Afghans were primarily interested in news programs on Western broadcasts and not in programs dealing with subjects such as science, sports, and music (UNO 1989).

According to the NBAS, approximately 69 percent of respondents listen to the radio—ranging from occasionally to daily. Most of the remaining 31 percent have no radio, and a small number said that no one in their household listened to the radio. As for radio station of choice, BBC and VOA are the clear favorites. BBC was the most popular (40 percent), followed by VOA (22 percent) as respondents' first choice.<sup>3</sup> Respondents clearly preferred news programs to other types of programs: more than one-half chose news; other types rated 5 percent or less.

As for NACP data, 22 percent had no radio, 35 percent listened sometimes, 21 percent listened regularly, and 20 percent listened daily. These last two groups constitute 3 of every 7 respondents, whereas only 1 in 26 watched television to the same extent. Of those with access to radio, 77 percent tuned in to BBC, whereas 8 percent listened usually to VOA. Almost all respondents chose news as their preferred program.

## TELEVISION

Least accessible among major forms of media, television coverage expanded under the communist government in Afghanistan. According to sources in the former regime, 7 television centers were operating at the end of 1985, and 20 stations were operating in 1986; however, these claims are suspect (UNO Afghanistan Information Handbook). Nevertheless, the former regime probably turned off more viewers than it attracted because of the communist nature of the programming.

Today, television is inaccessible to most Afghans. The NBAS results showed that 75 percent of households had no access to television. Kabul was the only area surveyed in which a large percentage of respondents reported watching television occasionally. In the other five provinces the percentages were small or nonexistent. Not surprisingly, Kabul television was the most preferred station, followed

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<sup>3</sup>Again, about one-third reported having no radio.

by Peshawar television. Some Kabul respondents listed Peshawar as the station of choice. Since it cannot be received in Kabul, they must have been referring to when they were refugees in Peshawar or nearby areas.

In the NACP survey, 92 percent had no television set or no access to one. The overwhelming majority of those who did have access tuned in to the Peshawar station. The greater access to television in the NBAS is due to the elite status of the survey population compared with the NACP survey population.

### **FOLK MEDIA**

In Afghanistan today, folk media are largely confined to drama and comedy performances at weddings or festivals. In recent years, these performances have become more constrained, in line with the rise of fundamentalist Islamic belief. Nonetheless, some effective use has been made of them for antinarcotics activity as noted later in this report.

## 7. Possibilities for Action

Several possibilities exist to reduce demand through increasing awareness of and decreasing use of narcotics, especially heroin, and through promoting treatment of addicts. These possibilities are illustrated by the public health model in Figure 1. The public health model focuses on community-level health issues and on making recommendations that the community can implement to achieve better health for all its members. These possibilities for demand reduction are constrained, however, by the media's shortcomings in carrying messages to Afghans, as well as institutional weaknesses in promoting awareness and treatment.

### **AWARENESS PROMOTION PROGRAMS**

#### **NACP**

The Narcotics Awareness and Control Project (NACP) sponsored by A.I.D. and based in Peshawar, ran from 1990 to 1991. NACP has contributed a great deal to the awareness programs and materials targeted at Afghans and available to the international and Afghan communities. NACP was a comprehensive program of research, testing, production of materials, outreach work, and awareness programs. A significant asset of the NACP was its interlinked program of training and education.

#### ***Camps***

The NACP pioneered camp awareness programs (4 hours to 2 days long) incorporating video and television, antidrug sermons, speakers' contests, poster competitions, "healthy" alternatives (volleyball and Afghan sports), and, most successful with the Afghan audiences, live dramas. The audiences for the last ranged from several hundred to two thousand. Target audiences were adolescents, elders, teachers and other professionals, and the general public. (Opinion polls were taken among the audience at some of these events.)

#### ***Afghan Media Research Centre***

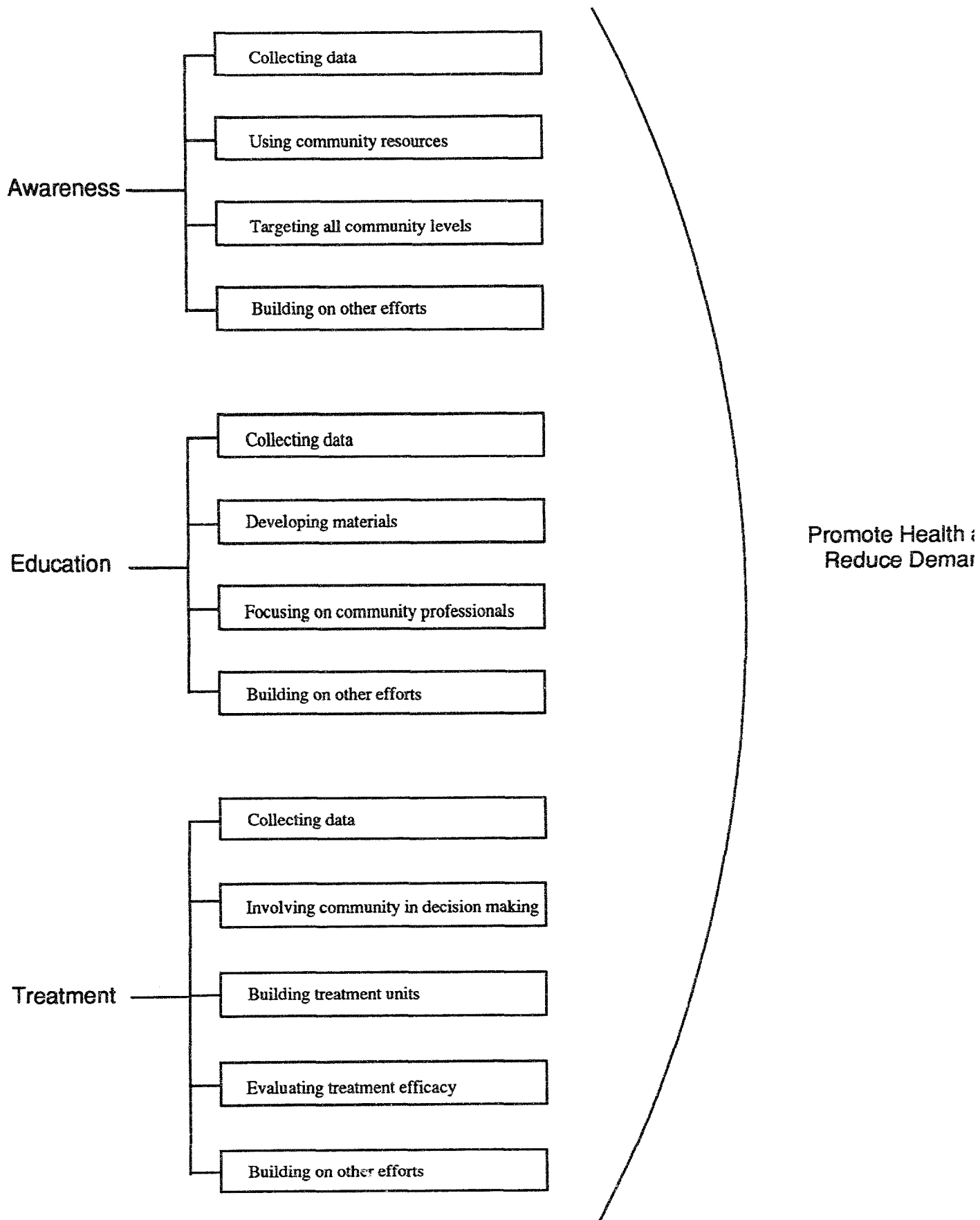
In 1990, as part of the NACP, the Afghan Media Research Centre (AMRC) in Peshawar developed media materials for use in drug awareness programs. These materials consisted of a video-documentary, six radio features (dramas), a series of educational booklets and pamphlets, and a set of six posters.

#### ***Documentaries***

The video-documentary "Drugs and Society" (18 to 24 minutes; Pashto and English) was produced by AMRC from archive materials and new segments filmed in Afghanistan and the NWFP. Before this film, leaders of the Afghan movement in Pakistan generally denied that Afghans were using heroin. The film showed poppy fields and interviewed farmers in Nangarhar and heroin dependents in the NWFP. The film showed the leaders that Afghans were not immune to heroin abuse.



**Figure 1. Public Health Model**



### *Radio Features*

Six radio features (8 to 15 minutes each; Dari and Pashto) were produced in the AMRC studio for broadcast by *mujahidiin* radio stations. Topics included interviews with heroin dependents and doctors, religious leaders, and farmers, presenting antidrug information.

### *Posters and Pamphlets*

Six brochures (8 pages each; Dari and Pashto) were produced, written in simple language, on drug abuse problems, heroin, drugs and Islam, farmers and drugs, teachers and drugs, student youth and drugs. Two pamphlets (in Dari and Pashto) on similar topics were produced for a more educated audience.

Six posters were designed and produced. Three depicted, respectively, a drug dependent imprisoned in a poppy bulb, a drug dependent drowning in the quagmire of drugs, and drug dependents using drugs while sitting in a ruin as other Afghans were busy with reconstruction work.

According to tests conducted by NACP, the response to these audiovisual materials was in general very positive among the Afghans exposed to them. The AMRC also produced some television news segments for the Cable News Network (CNN) on drug issues.

### *Calendars*

Many teachers asked NACP for maps of Afghanistan showing "healthy" crops for display in the camp schools. In response, NACP produced a calendar that was distributed within Pakistan and in the communities inside Afghanistan requesting such materials.

### *Afghanistan*

#### *Awareness Programs*

NACP conducted awareness programs inside Afghanistan, similar to those mentioned earlier, in some rural areas and district centers, such as Nangarhar, Logar, Paktia, and Konar. Local leaders served as masters of ceremonies, gave keynote speeches, and delivered sermons. Six programs were conducted until July 1991, when project staff were forbidden to cross the border. Some of the awareness materials produced by NACP were also distributed across the border.

#### *Drama Group*

The most impressive antidrug outreach tool was the drama group, for which young Afghan actors were given scripts, which they modified, and wrote their own pieces. Two dramas were rehearsed and staged during the life span of NACP. The troupe was scheduled to tour with the awareness programs and the mobile audiovisual program (see next subsection); however, the entire project was terminated, and the NACP troupe was dissolved.

#### *Roving Van*

NACP instituted a mobile audiovisual program, sending a roving antidrug van to various communities to show a large-screen video production and disseminate other aids (banners, posters, a photographic exhibition, and brochures) announcing awareness events.

### *Creation of Cadre*

From its inception, NACP focused on training in drug issues. First the program trained its own staff, and eventually expanded its training to teachers, elders, health workers, and other community members. The lectures started as 1-hour lectures and evolved into 2-week courses. NACP trained some 100 Afghans during its existence.

## **United States Information Service**

### ***USIS Peshawar***

The American Center in Peshawar has been quite active in promoting drug awareness among Pakistanis and Afghans. At the end of 1983, a guest speaker sponsored by USIS introduced the heroin detoxification regimen now used in the NWFP.

### *Lectures and Dramas*

Among the events USIS has sponsored are lectures, trips to the United States for further exposure to antidrug programs, and musical fund-raisers to support antidrug programs by Pakistani PVOs. In addition, Peshawar speakers have appeared in Worldnet discussions on drug topics, and the NACP staged one of its dramas in the American Center.

### *Books and Tapes*

The American Center has in stock many books and videotapes on drug issues. In early 1992, the holdings of the defunct NACP were incorporated and are on display in the library. Currently several hundred books and reports and about 50 videotapes on drug issues are available.

### *International Narcotics Information Network*

The center distributes the International Narcotics Information Network (ININ), a database on CD-ROM containing several hundred thousand pages on drug issues.

### ***Voice of America***

The VOA frequently broadcasts programs on drug-related issues.

## **United Nations Drug Control Programme**

### ***Camp Programs***

The United Nations, through the United Nations Drug Control Programme [UNDCP; formerly the United Nations Fund For Drug Abuse Control (UNFDAC)] began awareness programs in Afghan refugee camps in mid-1990, mostly in the Peshawar and Swabi/Mardan districts. Until now, several programs lasting from 2 to 4 hours have been held. The Peshawar office employs one awareness coordinator.

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## ***Programs in Afghanistan***

The UNDCP has been involved in the following programs:

- **Drug Information and Reference Centre.** The UNDCP discussed plans for a center with the Kabul government in 1991. The status of the plans is uncertain.
- **Demand Reduction.** UNDCP planned to support the Afghan government in the demand reduction sector in supporting manpower development, conducting research, and starting a data file. The status of these plans is also uncertain.
- **Awareness Campaigns.** The UNDCP is starting two awareness campaigns in Nangarhar and one in Badakhshan. UNDCP is also planning to initiate awareness programs in 18 additional districts in Nangarhar, around October 1992.<sup>4</sup>
- **Radio Programs.** At the end of 1990, UNDCP commissioned a radio program (a series of 12 short features) from the BBC's Pashto Language Programme. Since 1991 the BBC has broadcast these programs as part of its regular health program. The programs run from 6 to 10 minutes and deal with topics such as addiction and trafficking. In the NACP camp survey 48.4 percent of respondents mentioned that they had listened to drug programs on the radio (mostly BBC programs) of which they approved.

## ***Creation of Cadre***

Since mid-1990, UNDCP has provided training courses to Afghan social workers, mullahs, teachers, and health workers in Peshawar. So far, more than 500 people have been trained in courses lasting from 3 days to 2 weeks.

## ***Pakistani Programs***

### ***Drug Abuse Prevention Resource Centre***

The Drug Abuse Prevention Resource Centre (DAPRC) was established in 1988 to expand efforts to reduce demand for drugs in Pakistan and to support and mobilize efforts to prevent drug abuse. It was also designed to serve as a clearinghouse for antidrug information in Pakistan.

The DAPRC's strategy was to increase awareness on drug issues in the general public and certain crucial segments of population, by (1) educating policy- and decision makers about the Pakistan drug problem and its trends and presenting the solutions, and (2) developing an appropriate and unified reinforcing message on drug abuse prevention.

The Pakistan Narcotics Control Board (PNCB), established in 1972, began conducting research on drug abuse issues, including several national surveys on drug abuse, in 1982. In 1983 the PNCB began focusing on demand reduction by holding the first Workshop for Media Practitioners, sponsored by International Narcotics Matters (INM) of the U.S. Department of State. Before that time, PNCB was mainly a law enforcement agency that also ran a crop substitution program, as well as detoxification programs in cooperation with UNFDAC-World Health Organization and the provincial health authorities.

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<sup>4</sup>Interview with Zafar Rana, Programme Officer, UNDCP, Peshawar, Sept. 16, 1992.

### ***Media Practitioners' Workshops***

The first Media Practitioners' Workshop was held in late 1983. In May 1984, another workshop for several hundred participants brought positive results and considerably helped enhance the quality of print media reporting. Television, however, did not follow suit, and, until 1989, covered practically no drug issues.

Since 1984, there has been consistent reporting, not merely of the ubiquitous drug seizures, but of social and health-related drug issues as well.

### ***Print Media***

PNCB and the Punjab government launched a newspaper advertising campaign in 1984 and numerous others since then. Other print media developed by DAPRC include posters, brochures, and pamphlets, as well as an Urdu language journal.

### ***Broadcast Media***

A vigorous advertising program has been launched on radio and television. In Pakistan, there are 12 million licensed and 7 million unlicensed radios. Two-thirds of the listeners reside in rural areas, where 13.6 percent are estimated to be regular listeners and 20 percent occasional listeners. In comparison, only 3 percent of regular listeners live in cities, where radio has lost out almost entirely to television. Of the country's advertising expenditure, radio netted less than 4 percent, compared with 34 percent for television and 44 percent for print media.

### ***Exhibitions and Fairs***

First PVOs and later DAPRC operated booths at exhibitions and fairs (like the popular Islamabad Industrial Fair). Visitors were attracted to the booths, where personnel showed videos, gave advice, and handed out materials.

### ***Private Voluntary Organizations and Nongovernmental Organizations***

In early 1983, the first PVO-NGO administered detoxification programs in Karachi. Other NGOs soon followed, mostly in the treatment sector. However, when it became clearer and clearer that detoxification alone was not a total solution, several NGOs started or added prevention programs.

The first years of these programs (1984–1987) consisted mainly of afternoon or evening seminars and workshops. With greater exposure to international programs, study tours, and encouragement by the PNCB, PVOs gradually expanded their activities to encompass women's and youth rallies, anti-drug marches and began providing limited training. They became more active in exhibitions, maintaining contact with the mass media. Karachi, Rawalpindi, and Lahore were fertile ground for such PVOs.

In Peshawar, in December 1984, a PVO was established that combined treatment and rehabilitation efforts and prevention (and at a later stage, community outreach programs). This PVO and its successor pioneered family and community involvement and distinguished itself by involving social workers from the very beginning.

### ***Prevention Resource Consultants Network***

PVOs constantly lacked both financial and material (booklets, informational films, and slides) resources. The members also clearly lacked expertise and training. To counteract these constraints, in May 1989 the PNCB/DAPRC launched its Prevention Resource Consultants Network.

The goal of this program was to provide the awareness and prevention programs with a corps of trained cadres who would link government (DAPRC) and its resources and the PVOs, and also link treatment centers and the mass media. The advantage sought by launching this program was to create a corps of well-trained, locally available resources (from a broad range of professions) to handle funds and resources (such as videos and posters). This corps would cooperate with NGOs already involved in antidrug efforts and stimulate others to campaign against drugs. Part of the network involves a Master Trainers' training and several courses for social workers and journalists.

### ***Integrated Drug Demand Reduction Project***

To supplement its sponsorship of the development of drug education materials, training teachers, and supporting other awareness activities (such as posters and stamp competitions, exhibitions, and a mass media campaign), in 1991 UNDCP (and its predecessor UNFDAC) started the Integrated Drug Demand Reduction Project (IDDRP).

The IDDRP, a 5-year project, has been running for nearly 2 years. It is the follow-up project to two UNFDAC projects, each dealing with a facet of demand reduction—one on awareness promotion and one on treatment and rehabilitation.

One of the aims of the project is pre- and in-service training of teachers and revision of textbooks in their discussion of drug issues. The IDDRP has developed a course for students of the Distance Learning System studying to become teachers. A Community Action Project will support small-scale projects seeking to motivate communities to create healthy alternatives to drugs and develop skills in high-risk youth.

Other activities include the establishment of community information teams<sup>5</sup> within seven PVOs/NGOs and the appointment of four provincial coordinators to handle the demand reduction activities on both the treatment and the prevention side.

On the treatment side, pamphlets have been developed and distributed that present facts about drug abuse and explain how to prevent relapse. Also, assessment packages after medical detoxification have been disseminated.

A radio drama series of 13 units (30 minutes each) is in development and will be broadcast over the national network of Pakistan Broadcasting Corporation (PBC). There are also plans to have mobile units contact communities and administer drug awareness programs.

## **TREATMENT SERVICES**

Because none of the health workers interviewed inside Afghanistan had worked in addiction treatment units, we have no primary data on the characteristics of the treatment services inside Afghanistan. As a result, we base our information about treatment services entirely on personal interviews with various treatment directors and health workers in Peshawar. Peshawar is an area in which an overwhelming

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<sup>5</sup>The teams consist of two members—one for relapse prevention and promoting family involvement and follow-up work and one for awareness activities.

number of Afghan refugees have settled and therefore a number of services, including treatment, are geared toward them.

### Perception of Treatment

All the unit directors and health workers agreed that addiction is a serious problem among the Pakistani and Afghan populations. As discussed later, although all the units were almost fully operational, all the respondents reported a need for additional treatment facilities. One of the units is already constructing a new unit to expand its capacity from 10 to 40 beds, another is planning to develop a treatment unit for women, and yet another is planning to start several treatment units inside Afghanistan.

### Availability of Treatment

The team found that six treatment units serve the Peshawar community (see Figure 2 for a comparison of each unit's facilities):<sup>6</sup>

1. Caritas Pakistan,
2. Lady Reading Hospital (government operated),
3. Horizon inpatient treatment unit,
4. Horizon Rehabilitation Program (funded by the International Labor Organization),
5. Nejat Centre (funded by Orphans, Refugees, Aid International exclusively for Afghans), and
6. Khyber Teaching Hospital (government operated).

In addition, we interviewed an Afghan physician who ran a small four-bed unit that is no longer operational.

The Horizon Rehabilitation Program was the only outpatient rehabilitation program available—the rest treated addicts as inpatients. We later learned that the Government Mental Hospital also operated a 20-bed detoxification unit, but we did not collect any information about it because we assumed it catered to patients dually diagnosed as mentally ill and addicted. Treatment services throughout Pakistan consisted of about 36 treatment units (government operated) and an undetermined number of private physicians who treat addicts on an individual, fee-for-service basis. With an addict population exceeding 1 million, unit directors believe a large gap still exists in treatment availability. One respondent reported that about 3 years ago he was involved in a planning body for addiction treatment. At that time, a need for 6,000 beds was estimated; today, only 300 beds exist.

Each of the inpatient units had 10 beds. Caritas Pakistan is building a new 40-bed unit, 20 of which will be available for use in January 1993. The length of stay in most of the units varied between 8 and 10 days; Nejat Centre was the only unit allowing a 30-day stay. The Horizon-International Labour Organization (ILO) Rehabilitation Program is a 1-year outpatient program. All the unit directors maintained that their utilization rate exceeded 90 percent. However, in one of the units we visited, 7 of the 10 beds were vacant, but this may have been due to the impending religious holiday. All the units had waiting lists ranging from 1 to 6 months. Nejat Centre was fully booked for the remainder of the year, and its director reported having about 120 individuals on the waiting list.

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<sup>6</sup>Although it supports the Horizon inpatient treatment unit in Peshawar, UNDCP does not currently support any addiction treatment programs inside Afghanistan.

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## Figure 2. Treatment Units

Program Components	Caritas Pakistan	Lady Reading Hospital	Horizon	Horizon Rehabilitation Program	Nejat Center	Khyber Teaching Hospital Psychiatric Department
Type of unit	Inpatient free-standing 10-bed	Inpatient hospital-based 10-bed	Inpatient free-standing 10-bed	Outpatient	Inpatient free-standing 10-bed	Inpatient hospital-based 10-bed
Funding source	Catholic diocese	Government	UNDCP	International Labor Organization	Orphans, Refugees Aid International	Government
Patient fees	Yes	No	No	No	No	No
Length of stay	8 days	10 days	10 days	1 year	30 days	8 to 10 days
Utilization rate	less than 90 percent	100 percent	100 percent	NA	100 percent	100 percent
Waiting list	1 to 2 months	6 months	3 to 4 months	6 months	Booked for 1992 (120 people on list)	1 month
Total number treated last year	350 to 400	490	350	60	100	350
Number of Afghans treated last year	about 40	74	350	2 to 8	100	Minimal number
Average age of patient	26 to 30	NA	20 to 35	NA	20	20 to 35
Attrition rate	Negligible	Negligible	Negligible	Negligible	Negligible	20 percent
Relapse rate	70 percent	90 percent	70 to 90 percent	NA	10 percent	50 percent
Medications used	Opium, analgesics, largactil, phenobarbital	Opium, chlonidine, painkillers	Opium, chlonidine, painkillers	No medications used	Largactil, diazepam, vitamins	Chlonidine and experimentation with nalaxone and naltrexone
Staff	1 unit director 7 health workers (paramedics)	1 medical doctor 1 medical intern 2 psychologists 4 RNs 1 unit director (M.D.)	1 psychiatrist (M.D.) 1 social worker 2 RNs 1 psychologist 1 unit director (M.D.)	1 unit director (M.D.) 1 clinical psychologist 2 social workers 3 group leaders	1 unit director (M.D.) 1 medical doctor 4 nurses (paramedics) 1 social worker	1 unit director (M.D.) 1 medical officer (M.D.) 5 paramedics 2 orderlies

Note: NA indicates information not available.



## Treatment Process

Our general impression from the interviews was that most of the inpatient units basically offered detoxification services. Although a large number of individuals in treatment were addicted besides heroin to cannabis and opium, treatment was concentrated on heroin addiction. Health workers agreed that heroin addiction is the most serious of the three drugs.

The treatment regimen varied among the units. In some units opium was used as a substitute drug in combination with tranquilizers—largactil, diazepam, and phenobarbital—and analgesics. In others, chlonidine (Catapres) was used along with tranquilizers. In one of the units, naloxone and naltrexone were being used experimentally on a few patients. Where medical staff were employed, patients were given a physical check-up, an X-ray, and blood and urine tests as necessary. Nejat Centre was the only unit that reported using vitamins as part of their treatment. This center was also the only inpatient program with a semistructured follow-up program. Their clients returned for "counseling"<sup>7</sup> for 3 months after discharge. If they were financially unable to make the trip back, the unit's "social worker"<sup>8</sup> visited them regularly to follow up on their progress. Caritas Pakistan plans to establish a simple follow-up program in the near future; currently their resources are limited. They had conducted a survey of past patients and were able to find out that about 40 percent had remained drug-free. The Horizon Rehabilitation Program, a follow-up program, is discussed fully later.

The overwhelming majority of the units serve male patients; one inpatient unit (Horizon) has two beds designated for females, and another has treated some wives of patients informally as outpatients. Many of the health workers mentioned that women also experience opium and heroin addiction and that treatment for them is needed. This is quite interesting because all the health workers inside Afghanistan said women have no problems with drug use.

Caritas Pakistan is the only fee-for-service unit. Caritas believes that paying for the treatment encourages patients to complete it. The center used to experience a very high attrition rate before establishing a fee. In the other units, the directors reported negligible attrition because they do not admit patient unless they are certain of their own motivation.<sup>9</sup> One respondent told us: "We do not let them leave; they sign a paper at admission that they will complete the program."

Records are kept on all patients. All the units have an intake form that requests information about past drug use, family history, demographics, and other data. Some of the units keep the data electronically. As an alternative to primary data collection, A.I.D. may want to consider collecting data through record abstraction in order to fully describe the treatment process.

## Entry into Treatment

Entry into treatment did not vary across the units. Word of mouth was the only "advertisement" for services. Usually, family members and friends encourage a client to obtain treatment, although no "coercion" into treatment was documented. The heroin addicts we interviewed reported that the

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<sup>7</sup>No formal counseling is conducted because none of the health workers is trained as a counselor. Instead, the staff talk to the clients, find out how they are doing, and offer their encouragement.

<sup>8</sup>When interviewing this person, we learned that he had worked there as a social worker for only 3 months and had volunteered at the unit for 3 months before that. He had no formal social work training and was a pilot before joining the unit.

<sup>9</sup>Patients are interviewed before admission and refused if they are under pressure from family and if the staff are not convinced that the clients are personally motivated.

consequences of heroin abuse finally got them into treatment. They reported that heroin "destroyed" their health, marriages, families, and, for those who worked, their income sources. It was also interesting to learn that units did not accept patients if they came only on the basis of recommendations by families or friends. In a number of the units, the directors reported that during a preadmission interview, if they detected that a client was not highly self-motivated, they refused him admission. We were unaware of legislation for compulsory treatment and thus could not document any connection between the criminal justice system, other social services, and treatment. This differs greatly from countries such as the United States, where the majority of clients enter treatment through some form of "coercion" from the criminal justice system, from families and friends, or from employers.

## **Treatment Staff**

Because staff are an important component of treatment, we collected information about their training and background. Although treatment necessitated the dispensing of medications, not all units employed medical staff. Units that did employ medical staff were in a position to report co-morbidity of clients and to either treat them or refer them to medical doctors. As reported by the unit directors, the majority of the staff were university trained. For example, the Horizon inpatient unit employed a psychiatrist (M.B.B.S.), two registered nurses, and one social worker, while the outpatient rehabilitation program employed a clinical psychologist (master's degree), two social workers, and three group leaders.

The group leaders were recovering addicts from Horizon's inpatient programs who had been trained by the center in addiction treatment. However, we found that this was not always the case. The health workers at Caritas were all trained on the job by the director or other senior staff. Except for two who had only elementary education, the rest had matriculation certificates. The "nurses" at Nejat Centre were not medically trained but were hired to "talk with" female family members when they came to visit patients. Except for Nejat Centre, whose staff were all Afghans, and Horizon, where one staff member was an Afghan, all the health workers in the other units were Pakistani. Working there were one unit director (a medical doctor) serving the two Horizon units and Lady Reading Hospital unit, a foreign-born priest for Caritas Pakistan, an Afghan psychologist for Nejat Centre, and a Pakistani psychiatrist for the Khyber Teaching Hospital unit. An Afghan medical doctor had been operating a four-bed unit, but it is no longer functioning.

Although all the programs were briefly discussed earlier, it is useful to describe in more detail the outpatient program operated by Horizon and ILO. The program was initiated in January 1992 as an experimental outpatient program focusing on rehabilitation, relapse prevention, and social reintegration of clients into the community. This unit could perhaps serve as a model program for future A.I.D.-supported rehabilitation centers. The clients who join this program have already been detoxified and join the program for a year. At the time of the interview, September 1992, the program had 60 clients of whom 9 had dropped out and 3 had returned. The program uses a variety of treatment approaches: self-help groups, including a religious group; income-generating and placement activities; recreational activities; family and peer involvement in treatment; home delivery programs (in which social workers visit the patients in their homes as part of a follow-up); and staff training. The program also frequently assesses the progress of clients. Another innovative approach used by this program is training mullahs in how to treat addicts. Mullahs are brought to the center, educated about the nature of the disease, and encouraged not to stigmatize the addicts.

## Effectiveness of Treatment

Because there is some evidence that clients who are motivated perform better in treatment (Institute of Medicine 1990a), we asked our respondents how they perceived the effectiveness of their treatment regimen. Except for the Horizon Rehabilitation Program, the other units had no formalized measurement of effectiveness in place. Caritas had conducted a survey of past clients in which they found that about 40 percent of their clients had remained drug-free.

There were some discrepancies in the opinion of the staff regarding the effectiveness of the treatment they were offering and their estimate of the relapse rate of clients. Four of the six health workers we interviewed reported that their treatment was always effective, and the other two reported that it was mostly effective. Yet, when asked about client relapse, most of them reported a rate of more than 50 to 70 percent. It is possible that they were answering the effectiveness question for treatment in general rather than for any specific treatment program, or perhaps they did not want us to form a negative opinion of their program. The unit directors were more realistic in their estimates. Except for Nejat Centre and the outpatient program, the unit directors estimated a relapse rate between 50 and 90 percent. The director of Nejat Centre estimated that only 10 percent of their patients relapse; the outpatient program could not predict its relapse rate because it is still relatively new.

None of the units was conducting a long-term formalized follow-up of clients. Without such structured follow-up, it would be impossible to evaluate the success of treatment in rehabilitating clients and keeping them drug-free.

## LESSONS FROM PAKISTAN FOR FUTURE AFGHANISTAN PROGRAMS

Pakistan and the United Nations initially concentrated their entire efforts on detoxifying opium and charas addicts (1976–1980). By then, the heroin wave had begun relatively unnoticed. Since 1982, patients in the treatment centers have been exclusively heroin dependent. The success rate had not been more than 10 percent, relapse was the norm, and many patients visited clinics 10 or more times. After 1984, private practitioners who had been trained by PNCB/INM shared in the detoxification burden.

During this time, Pakistan made virtually no efforts in awareness promotion and prevention. The official denial of heroin problems lasted certainly until the end of 1982 or 1983, despite the start of the heroin wave by the beginning of 1980. The first, if feeble, awareness efforts were launched by the end of 1983, aimed at mass media practitioners.

When prevention efforts were undertaken more coherently, starting in 1986, it was far too late. By then the number of heroin dependents had risen to a reported half a million. By the time the campaign had become effective, by about 1987, the addicts and their non-using friends had long since learned the dangers of the drug by themselves.

Several lessons have been learned. First, prevention and awareness efforts should ideally begin before any prevalence of drug use or, at the latest, in its initial stages. In a country such as Pakistan (and, by inference, Afghanistan) with underdeveloped infrastructure in this field, at least 5 years must pass before a nationwide effective prevention network and appropriate awareness campaigns (not merely relying on and limited to the mass media) are in place. Hence, such efforts should ideally be administered before crop substitution or treatment programs.

Eventually the PNCB quite successfully employed mass media (in particular, television spots, films, cinema spots, and newspapers). Authorities successfully enlisted the mass media (in particular, the print media) through arranging workshops for the media practitioners. For a more intensive

approach in raising concern and awareness (and in following up on mass media efforts), interpersonal communication (awareness events and dramas) have proved useful among Afghan refugees.

In general, apart from mass media programs, programs using interpersonal communication and the proper mix of communication messages and appropriate channels, and offering more than merely narcotics-related topics stand the best chance of being received and accepted by the Afghan population.

Narcotics-related topics should be interlinked with religious, social (health, education, family matters), and agricultural topics.

## Future Options

The Nathan-Berger report *A.I.D. Mission Options for a Drug Control Strategy* presented a comprehensive model to assist A.I.D. in developing an antinarcotics policy for Afghanistan. We presented enforcement, community development, and public health approaches as components of a unified policy. In this report, our recommendations are targeted to drug use and media accessibility. There is no doubt about the critical need for data in guiding any policy making. This is especially true of Afghanistan now as the needs of the country span all sectors. Therefore, we present the following recommendations:

- Develop and implement a narcotics policy for Afghanistan at various levels: local, community, city, country, and international. We recommend the involvement of many institutions in this development: educational, religious, medical, and criminal justice (law enforcement). The policy should tackle both supply and demand reduction.
- Establish baseline and repeated data collection about drug use similar to household surveys conducted by the National Institute on Drug Abuse (NIDA) in the United States. However, such a survey may be too ambitious for several reasons: political instability is not conducive to collecting household data; the displacement and subsequent resettlement of refugees will change the structure of society; and, to our knowledge, Afghanistan has not recently conducted a national census—without which it is difficult to conduct national surveys. In view of anticipated political stability in the region, Afghanistan may be planning to conduct a national census from which a wide range of sample surveys in all sectors can be conducted. Associated with conducting national surveys is the building of a cadre of data collectors who are committed to gathering quality data. In the absence of these possibilities for surveys, conduct ethnographic data to study prevalence of drug use.
- Establish a surveillance program whereby data are continually entered from hospitals, emergency rooms, doctors offices, and the like about drug-related injuries.
- Plan to complete the Nathan-Berger survey of health workers inside Afghanistan.
- Once data have been gathered, plan and implement a multimedia awareness and education campaign targeted to all population groups, young and old, educated and uneducated, urban and rural, while building on existing programs such as those being implemented by UNDCP.
- Establish treatment programs focusing on rehabilitation therapy. Treatment will focus on reintegrating addicted individuals into society. Establishing these programs also involves the training of addiction treatment personnel, including medical and paramedical professionals.
- Plan and conduct longitudinal follow-up studies to evaluate the effectiveness of treatment.
- Establish health indicators dealing with addiction and monitor progress toward achieving them. We recommend that diverse knowledgeable locals be involved in charting these indicators. This is an activity similar to the Healthy People 2000 effort.

- Develop and implement educational programs at many levels, targeting various population groups, such as school-age children, youth, adults, women, religious community, employers, and medical and paramedical personnel.
- Establish a cadre of professionals to conduct awareness, treatment, and other drug-related programs. For example, continue and enhance the training of health workers and teachers initiated by A.I.D. and other agencies such as UNDCP. Build on the initiative of DAPRC to train social workers in awareness and implementation of antidrug community programs, and then send them into the communities to implement those programs. Finally, train a cadre of professional data collectors who will be responsible for collecting new data as well as updating already existing data.

## Testing

It is conceivable that resorting to drug-screening technology, in addition to data collection, may be an option to estimate the level of drug abuse, because there is strong evidence that self-reports have not always been successful. Our interviewers reported that respondents were not truthful when answering questions about drug use. For example, one interviewer told of a respondent who was chewing naswar but denied using it when asked a question about it. Besides dealing with whether A.I.D. wants to invest the resources in medical testing, we must also deal with the problem of convincing respondents to provide samples of blood, urine, or hair. Clearly one successful means is to pay respondents for the sample. The costs for A.I.D. must also include shipping the samples to the United States because we assume that such sophisticated testing procedures may not yet exist in Afghanistan.

The development of immunochemical drug assays has been a major element in advancing our knowledge about drug use. Urinalysis has become a highly used test because it provides high degrees of sensitivity and specificity very cost-effectively. However, urine tests can detect the presence of drugs only over a short period of time, typically 2 to 5 days after use—except marijuana, which can generally be detected from 5 to 30 days after use. Thus, urine measurements are not representative of long-term use. Moreover, although urine tests can detect the use of drugs, they cannot estimate the amount of drugs consumed. Urinalysis may also yield a positive result not because of drug use but from having been contaminated as a result of drug dealing activities. Moreover, all urinalysis tests employ arbitrary cutoff levels.

Hair testing, however, has many unique contributions that make it attractive, including cost-effectiveness. Although hair analysis is more expensive than urinalysis, it does not need to be conducted as frequently because its retrospective period spans several months. In addition, hair analysis has the potential for quantifying dosage, which urinalysis cannot, and can detect very low levels of chronic drug use. A large body of scientific literature supports the usefulness of hair analysis, and courts have admitted hair analysis results as evidence in a number of cases, like a recent one in the *New York Law Journal* (1990). However, like the initial controversy surrounding urinalysis, there are some controversial issues involving hair analysis. The first relates to the interpretation of hair analysis outcomes and how these outcomes may or may not be appropriately employed. Second, hair analysis may identify drugs that have been retained in the hair from passive exposure. Third, no established set of quality control standards is yet in place for laboratories performing this procedure. Proponents of the test argue that the clinical utility of the test, especially when used with other types of data, offsets the disadvantages. Moreover, although they agree that quality control measures have not been standardized, the one major laboratory conducting the test uses internal measures. As for passive exposure, there are data showing that certain washing techniques can distinguish between passive and active drug use (Mieczkowski 1992; Baumgartner and Hill 1990). It is curious that hair

analysis is now generating controversy, because it has been used to detect the presence of metals or nutrients for almost 20 years. Provided the resources and agreement by respondents to participate, hair analysis may be a viable way to estimate the prevalence of drug use among Afghans.

## Media

Current and future decision makers might consider newspapers as an option to reach target audiences. However, for the vast majority of the population, in particular rural (poppy-growing) areas, radio will continue to be the medium most accessible and available to a sizable segment of the Afghan population. Radio's rural reach gives it the unique advantage of serving as an effective communicator of social and educational messages. Experiences in other Asian countries with drug control efforts have demonstrated that the most effective programs "wrapped" antidrug messages in an attractive package containing entertainment, drama, health, and educational messages.

A multimedia campaign, sustained over time, has proved to show better results than a "one-shot" approach, especially in a traditional society such as Afghanistan. A campaign tailored to several media is preferable to a campaign tailored to one medium. In addition, means of interpersonal communication should be used to influence attitudes, since Afghanistan is characterized by extremely low television penetration, low literacy, and few entertainment opportunities. A multiple strategy should be used when attitudes need to be corrected and behavior changed, rather than merely relying on a mass media approach. Interpersonal communication is the culturally suitable and, most likely, the only key to creating awareness, raising concern, and effecting desired change in attitude and behavior.

Nevertheless, the potential usefulness of television is high, particularly among the affluent population of the larger cities; this medium thus deserves consideration even if its usefulness in rural areas is currently rather limited.

Other media, such as folk media (dramas), songs and movies, sermons and recited poems, can provide valuable channels of communication. NACP and UNDCP have found drama to be the most attractive awareness program component, drawing great numbers of spectators and visibly moving them. However, inside Afghanistan, with its small and isolated villages, audiences are more scattered than they were in the refugee camps. Thus, drama presentations could be videotaped and broadcast or mobile awareness teams could present the tapes.

Choosing the right mix of media and use of the proper messages is a crucial prerequisite to achieving the desired impact.

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**Appendix**  
**PERSONS INTERVIEWED**

**Amhad Chafiq, M.D.**  
Director  
Drug Treatment Unit  
Khyber Teaching Hospital  
Peshawar

**Hank Cushing**  
Regional Affairs Officer  
A.I.D./Afghanistan  
Peshawar

**Richard English**  
Development Alternatives Inc.  
Washington, D.C.

**Gerald Feierstein**  
Principal Officer  
U.S. Consulate  
Peshawar

**Azam Gul**  
Director  
Agricultural Survey of  
Afghanistan  
Swedish Committee for  
Afghanistan  
Peshawar

**Roger Helms**  
A.I.D./Afghanistan  
Peshawar

**James Hughes**  
Resident Agent In Charge  
U.S. Drug Enforcement  
Administration  
Peshawar

**John Humphrey**  
Afghanaid  
Peshawar

**Anne Hurd**  
Koh-I-Noor  
Peshawar

**John Huxtable**  
Food for Peace Officer  
A.I.D./Afghanistan  
Islamabad

**Abdul Khaliq**  
In-Charge Refugee Camps  
(Naib Tehsildar)  
Dalbanin

**Gulzar Ahmad Khan**  
Secretary for Home and Tribal  
Affairs  
Northwest Frontier Province  
(former Commissioner for  
Afghan Refugees, Government  
of Pakistan)  
Peshawar

**Jehanzeb Khan**  
ACC Coordinator  
Afghan Rehabilitation  
Reconstruction Project  
U.N. International Drug Control  
Programme  
Peshawar

**Gary Lewis**  
A.I.D./Afghanistan  
Islamabad

**Ken Lizzio**  
Former Narcotics Awareness  
and Control Programme  
Washington, D.C.

**James Magnor**  
Counselor  
Narcotics Affairs Section  
U.S. Embassy/Islamabad

**Mr. Mahsood**  
Freelance Journalist, Reuters  
Peshawar

**Taj Mali**  
Public Affairs Assistant (Afghan  
Program)  
U.S. Information Service  
Peshawar

**Akbar Marri**  
Tehsildar  
Dalbandin  
District Chagai  
Girdi Jungle Area

**Gulzar Marri**  
Village Administrator  
Quetta/Surkhab Refugee Camps  
Quetta

**Jack McCreary**  
Press Attaché  
U.S. Information Service  
Islamabad

**Taj Mohammad Mengal**  
Assistant Director  
Pakistan Narcotics Control  
Board  
Quetta

**Michael Mingo**  
Public Affairs  
Commissioner/Consul  
U.S. Information Service  
Peshawar



**Rustom Shah Mohmand**  
Commissioner for Afghan  
Refugees  
Government of Pakistan  
Peshawar

**Tom Morrison**  
Director  
Agrisystems (Overseas) Ltd.  
Swedish Committee for  
Afghanistan  
Peshawar

**Khalid A. Mufti, M.D.**  
Executive Director  
Horizon Agency Head  
Department of Psychiatry  
Medical Institute  
Peshawar

**Abdul Hakim Murad**  
Training Center Manager  
Agriculture Department  
Swedish Committee for  
Afghanistan  
Peshawar

**Al Nehoda**  
A.I.D./Afghanistan  
Peshawar

**Hans (Pat) Peterson**  
Director  
Office of Agriculture  
Bureau for Research and  
Development  
A.I.D./Washington

**Andrew Pryce**  
Chief Technical Adviser  
Afghan Rehabilitation  
Reconstruction Project  
U.N. International Drug Control  
Programme  
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**Arnold Radi**  
Chief  
Office of Agriculture and Rural  
Development  
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**Zafar A. Rana**  
Programme Officer  
Afghanistan Rehabilitation  
Reconstruction Programme  
U.N. International Drug Control  
Programme  
Peshawar

**Rev. Gregory P. Rice**  
Director  
Caritas Pakistan Drug  
Abuse Treatment Programme  
Peshawar

**Malik Ulam Sadik**  
Narcotics Affairs Section  
Peshawar

**Christine M. Sheckler**  
Program and Narcotics Officer  
A.I.D./Pakistan  
Islamabad

**Ikram Shinwar**  
Voice of America  
Peshawar

**Joanne Thompson**  
International Narcotics Matters  
State Department  
Washington, D.C.

**Miles Toder**  
Deputy Chief of Party  
Afghanistan Agricultural Sector  
Support Project  
Development Alternatives Inc.  
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**Robert Traister**  
Narcotics Affairs Section  
Peshawar

**Mohammed Umer**  
Deputy Director  
Pakistan Narcotics Control  
Board  
Quetta

**Curt Wolters**  
A.I.D./Afghanistan  
Islamabad

**Pashtoon Yar, M.D.**  
Peshawar

**Anwar Zai**  
Agriculture Program  
Swedish Committee for  
Afghanistan  
Peshawar

**Qasim Zamani**  
Director  
Nejat Center  
Peshawar

Numerous Afghan refugees,  
including those in

- Malgagae and Muslim Bagh camps, where refugees are from Zabul and Uruzgan provinces;
- Surkhab and Mahammad Khel camps, where refugees are from Qandahar and Uruzgan provinces; and
- Girdi Jungle and surrounding camps, where refugees are primarily from Helmand, but some are also from Qandahar and Nimroz provinces.